DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

July 27, 2010

Christine Neuhoff, System General Counsel St Lukes Regional Medical Center 190 East Bannock Street Boise, ID 83712

CMS Certification Number: 13-0006

Re: Plan of Correction Received

Dear Ms. Neuhoff:

The Centers for Medicare and Medicaid Services (CMS) has received St Lukes Regional Medical Center's voluntarily submitted plan of correction following the June 10, 2010, survey. CMS appreciates the time and effort of you and staff in developing and implementing the plan of correction. Please contact Kate Mitchell of my staff at (206) 615-2432 if you need further information.

Sincerely,

Steven Chickering Western Consortium Survey and Certification Officer Division of Survey and Certification

cc: Idaho Bureau of Facility Standards

C.L. "BUTCH" OTTER - Governor RICHARD M, ARMSTRONG - Director

DEBBY RANSOM, R.N., R.H.I.T - Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-036 PHONE: (208) 334-6526 FAX: (208) 364-1888 E-mail: fsb@dhw.idaho.goy

June 30, 2010

Gary Fletcher St. Luke's Regional Medical Center 190 East Bannock Street Boise, Idaho 83712

RE: St. Luke's Regional Medical Center, provider #130006

Dear Mr. Fletcher:

This is to advise you of the findings of the complaint investigation survey, which was concluded at your facility on June 10, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **July 13, 2010**, and keep a copy for your records.

Gary Fletcher June 30, 2010 Page 2 of 2

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

GARY GUILES

Health Facility Surveyor

Syera Geswell for

Non-Long Term Care

SYLVÎA CRESWELL

Co-Supervisor

Non-Long Term Care

SC/srp

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 29, 2010

Gary L. Fletcher, CEO St. Lukes Regional Medical Center 190 East Bannock Street Boise, ID 83712

CMS Certification Number: 13-0006

Re: Complaint survey 06/10/2010 and CoP not met

Deemed status removed and placed under State survey jurisdiction

Full health and life safety code survey to be conducted

Dear Mr. Fletcher:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on June 10, 2010. Based on a review of the deficiencies identified during this investigation, we have determined that St. Lukes Regional Medical Center is not in substantial compliance with the Medicare hospital Condition of Participation – Patient Rights (42 Code of Federal Regulations (CFR) § 482.13).

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. Therefore, as a result of the June 10, 2010, complaint survey findings, we are required following timely notification to the accrediting body, to place the hospital under Medicare State agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of St. Lukes Regional Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable within 90 days of completion.

You may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement
 actions into its Quality Assessment and Performance Improvement (QAPI) program,
 addressing improvements in its systems in order to prevent the likelihood of the deficient
 practice reoccurring. The plan must include the monitoring and tracking procedures to
 ensure the plan of correction is effective and that specific deficiencies cited remain corrected
 and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification Attention: Kate Mitchell 2201 Sixth Avenue, RX-48 Seattle, WA 98121 Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that St. Lukes Regional Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When St. Lukes Regional Medical Center has been found to meet <u>all</u> the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Page 3 - Mr. Fletcher

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Jelilyn McClair
Low Steven Chickering

Western Consortium Survey and Certification

Division of Survey and Certification

Enclosure

cc: Debra Ransom, Idaho Bureau of Facility Standards

The Joint Commission



190 East Bannock Street Boise, Idaho 83712

stlukesonline.org

Gary L. Fletcher, CEO

RECEIVED

JUN 29 2010

FACILITY STANDARDS

June 28, 2010

Kate Mitchell CMS Survey, Certification & Enforcement Branch 2201 Sixth Avenue, RX-48 Seattle, WA 98121

Re: Survey by Idaho Bureau of Facility Standards Ending June 10, 2010

Dear Ms. Mitchell:

The Idaho Bureau of Facility Standards ("BFS") indicated you will be the contact person with the Regional Office of CMS who will review the report that BFS prepared following the survey conducted at St. Luke's Regional Medical Center to investigate three patient grievances received by BFS. After our review of the preliminary findings, St. Luke's provided additional information to BFS for consideration in preparing their report submission for CMS. I understand BFS has forwarded our additional information to you. This information included: a letter from Gary Fletcher, CEO, dated June 14, 2010 with a binder of attachments (Memo from Chief Medical Officer to Chief Executive Officer Concerning Order for Versed Not Used as Chemical Restraint; Response to Preliminary Findings from the Bureau of Facility Standards Complaint Investigation, June 7-10, 2010; Revised Policy and Evidence of Education Provided to Records Release Personnel); and documentation of results of our investigation of an additional case identified to us by BFS surveyors after receiving the letter from Mr. Fletcher and the accompanying attachments. St. Luke's provided an additional communication to BFS on June 15, 2010 to include statements from Catherine Gundlach, PharmD, and Elizabeth Olberding, MD.

St. Luke's appreciated the opportunity to provide this additional information to BFS. We take these matters very seriously and immediately investigated and implemented interventions relative to the findings BFS identified during the exit conference. We had hoped that after reviewing the information provided, BFS would have reversed its initial findings of deficiencies relating to the following standards: A154, A166, A169, A178, A186, A187 and A188. The "Response to Preliminary Findings from the Bureau of Facility Standards Complaint Investigation, June 7-10, 2010" includes a summary of St. Luke's response, timeline, action steps and accountability for each of the Standards identified by the BFS surveyors at the conclusion of the survey. An addendum to this response was created as a result of the additional communications sent to BFS on June 15, 2010. During the two weeks since this document was provided to BFS, St. Luke's has continued to implement the action steps we



identified. For your convenience, I am enclosing a copy of the materials previously provided to BFS and evidence of additional action steps implemented.

I look forward to having an opportunity to discuss these matters with you later this week. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff

System General Counsel

General Counsel, Boise/Meridian

Enclosures

cc: Sylvia Creswell, Idaho Bureau of Facility Standards

Gary Fletcher, CEO, St. Luke's Boise/Meridian

Barton Hill, MD, VP Medical Affairs, St. Luke's Boise/Meridian

Joanne Clavelle, VP Patient Care Services CNO, St. Luke's Boise/Meridian



190 East Bannock Street Boise, Idaho 63712

stlukesonline.org

Gary L. Fletcher, CEO

July 13, 2010

Sent via facsimile to (208) 364-1888

Debby Ransom, RN, RHIT Idaho Department of Health and Welfare Bureau of Facility Standards 3232 Elder Street PO Box 83720 Boise, ID 83720

Re: CMS Certification Number: 13-0006

Dear Ms. Ransom:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated June 30, 2010, advising us of your findings relative to state licensure requirements.

Enclosed you will find our Plan of Correction, on State Form 7EK211, describing procedures we have implemented and/or begun to implement in response to the processes cited as deficiencies. This document references the Plan of Correction, on Form CMS-2567, submitted to the CMS Regional Office on July 9, 2010, which demonstrates how we are incorporating our actions into our quality assessment and performance improvement program to prevent the likelihood that any similar event(s) will recur. A copy of Form CMS-2567 has been enclosed for your reference. Mrs. Joanne Clavelle, Vice President for Patient Care Services and Chief Nursing Officer, will be responsible for implementing our Plan of Correction.

The deficiencies cited were of great concern to St. Luke's. Immediately following our exit conference with your surveyor team, we began to develop and implement the enclosed Plan of Correction. As you will see on the enclosed Plan of Correction we are promptly and diligently addressing the cited deficiencies.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff

System General Counsel

General Counsel, Boise/Meridian

Enclosures

cc: Kate Mitchell, CMS – Survey and Certification

Gary Fletcher, CEO, St. Luke's Boise/Meridian Barton Hill, MD, VP Medical Affairs & CMO

Pam Bernard, COO, St. Luke's Meridian Chris Roth, COO, St. Luke's Boise

Joanne Clavelle, VP Patient Care Services & CNO, St. Luke's Boise/Meridian



CONFIDENTIALITY NOTICE

The document(s) accompanying this telecopy transmission contains confidential information belonging to the sender, which is privileged. The information is intended only for the use of the individual or entity named <u>below</u>. If you have received this correspondence in error, please: i) safeguard the information and notify the sender immediately to arrange for the return of the information; OR ii) immediately shred or otherwise destroy the communication and notify the sender. Confidential information should not be disposed of in open waste receptacles or through other means that are not secure.

St. Luke's Regional Medical Center – 190 E. Bannock Street

Boise, ID 83702

Phone: (208) 381-1165 Fax: (208) 381-1185

E-mail: wilmesc@slrmc.org

Date:

July 13, 2010

To:

Debby Ransom, RN, RHIT

Idaho Department of Health & Welfare

Bureau of Facility Standards

From:

Christine Neuhoff

General Counsel

Fax:

208.364-1888

Number of pages including cover:

62

;2083812861

10/ 62

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/29/2010 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 130006 06/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) (D PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 000 **INITIAL COMMENTS** A 000 The following deficiencies were cited during the complaint survey of your hospital. The surveyors conducting the survey were: Patrick Hendrickson, RN, HFS, Team Lead Gary Banister, RN, HFS Gary Guiles, RN, HFS Teresa Hamblin, RN, MS, HFS Acronyms and terms used in this report include the following: ALF = Assisted Living Facility AMA = Against Medical Advice ED = Emergency Department HIM = Health Information Manager IV = Intravenous IM = Intramuscular LIP = Licensed Independent Practitioner MAR = Medication Administration Record MG = Milligrams PICU = Pediatric Intensive Care Unit PIE = Performance Improvement Event PRN = as needed Pt ≈ patient RN = Registered NurseSW = Social Worker A 115 482.13 PATIENT RIGHTS A 115 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interview, review of patients' medical records, hospital policies and procedures, grievance documents, medical records requests, and restraint logs, it was determined the hospital failed to ensure patients' DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE LABORATORY TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID; ID1LGZ

If continuation sheet Page 1 of 53

7/4

;2083812861

11/ 62

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI		G	(-
*******		130006	0, W)			06/10	0/2010
	rovider or supplier Es regional medic	al center		1!	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET BOISE, ID 83712		· .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFÉRENCED TO THE APPR DEFICIENCY)	OLD BE	(X5) COMPLETION DATE
	rights were protected inability of the hospit were respected and include: 1. Refer to A123 as hospital to ensure it findings to patients. 2. Refer to A129 as hospital to define hospital to define hospital to ensure it placed on involuntated. Refer to A131 as hospital to ensure it placed on involuntated. Refer to A148 as hospital to promote clinical record informs. Refer to A154 as hospital to ensure puthe hospital for med psychiatric admission of restraints impose. Refer to A166 as hospital to ensure horestraint usage into 7. Refer to A169 as	it relates to the failure of the provided a written notice of who filed grievances. It relates to the failure of the provided a written notice of who filed grievances. It relates to the failure of the patients on suicide watch phone. It relates to the failure of the perights of patients who were ry holds, were protected. It relates to the failure of the patient rights by releasing nation. It relates to the failure of the atients, who were admitted to ical clearance, pending a pen, were free from the threat d as a means of coercion. It relates to the failure of the ospital staff incorporated patients plans of care. It relates to the failure of the ospital staff incorporated patients plans of care. It relates to the failure of the ospital staff incorporated patients plans of care.	A	115			
	hospital to ensure pa for the management	it relates to the failure of the atients who were restrained t of violent behavior, received ation by an appropriately					

12/ 62 FNINTED: UD/29/2010 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130006	B. WI				
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 80 EAST BANNOCK STREET BOISE, ID 83712	, VVII.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(XS) COMPLETION DATE
A 123	qualified person with the intervention. 9. Refer to A186 as hospital to ensure lewere attempted befin physical restraints. 10. Refer to A187 a hospital to ensure the chemical and/or physical and/or physical documentation conditions and/or syluse of the restraints. 11. Refer to A188 a hospital to ensure the chemical restraints documentation in the response to the intervention of the practices seriously into promote and protopromote and protop	it relates to the failure of the ess restrictive interventions ore the use of chemical and/or it relates to the failure of the nat patients for whom sical restraints were used, in the medical records of the improvement of the mat patients for whom were used, had eir medical records of the restraints for whom were used, had eir medical records of the restraints for whom were used, had eir medical records of the restraints. TENT RIGHTS: NOTICE OF SION The grievance, the hospital steps taken on behalf of the eath grievance, the results of ss, and the date of the notice of its not met as evidenced by: view and review of hospital		115	In response to A-123 Action Plan Responsible Par Vickie Whitham, MS, RN, I BC, director Nursing Administration Process improvements: 100% of patient grievand have been resolved for the time period reviewed by surveyors (1/1/01-5/9/10 Finalized July 1, 2010. Plan to identify and implement an automated complaint reporting and tracking system. Project planning timeline being developed with anticipat implementation within 1	rty: NE- ces ne the)). ed 2 atient tion	
	policies and grievani	ce files, it was determined the				(<u> </u>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility IO: ID1LGZ

If continuation sheet Page 3 of 53

13/ 62

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
			130006	B, WIN			C 06/10/2	
, .,		ROVIDER OR SUPPLIER	AL CENTER	•	19	EET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET IOISE, ID 83712		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID P REF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	NTD BE	(X5) COMPLETION DATE
		patients (#27, #30, grievances were interpretation of a delay. The above policy winclude: a. Patient #33 was 3/23/10 and dischar in after Patient #33 refrorm the Endoscopy and when the patient of receipt of a formatime frame for review on the severity of the the review was comprovide the patient decision. Whenever grievances would be receipt. More comproved than 30 days policy did not addresand when the hospitor resolve the compressive than 30 days policy did not addresand when the hospitor resolve the compressive than 30 days and when the hospitor resolve the compressive than 30 days and when the hospitor resolve the compressive delay.	ovide written notice to 4 of 5 #31, and #33) whose tiated between February and ose grievance files were ulted in delayed responses to s. The findings include: Patient Concern, Complaint, cess, dated 6/04/09, had a ligating and Responding. It dgement letter would be of/representative within 7 days al complaint/grievance. The w and investigation depended the complaint/grievance. After oplete, the hospital would with a written notice of its or possible, concerns and the resolved within 30 days of olex grievances might require to reach resolution. The ss the procedure to be taken if tal was not able to investigate obtaints within the timeframes policy, such as whether they complainants to let them know as not followed. Examples a 31-year-old female admitted (ged 3/28/10. A Performance (PIE), dated 3/25/10, I, described an event that of the pointed out a	Α-	123	In response to A-123 cont Update of Patient Compla and Grievance policy to include the provision for patients will be informed it writing if the investigation into their grievance will ta more than the "suggested" day timeframe per our policy Some grievances require extensive investigation and are subject to the Peer Rev processes, requiring > 30 cfor resolution. Approved 22, 2010 The current process of reviewing a regular report track unresolved grievance past 30 days will continue. The Patient and Family Relations team will collaborate with department leadership team to fast track resolution where possible.	int in	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDII B. WING _		(·
		130006	3. 141143		06/10)/2010
	NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 123	dark bruise to her kein the Endoscopy Dideeply and then pinthe bruising. She was a bronchoscopy is a tracheobronchial tree. An email communic documented Patiengrlevance. A Performance of Patiengrlevance of Patiengrievance on behalf did not receive an a 7 days of initiating the hospital policy. The Concern Report also been "sent for review assigned to be the I assigned to be the I assigned to be the I buring an interview Manager of Patient of a "paper system" the time the complated partment and the Relations where conintiated. She also storwarded to the Endoscopy is a sent to the Endoscopy of the time the complated partment and the Relations where conintiated. She also storwarded to the Endoscopy is a sent to the Endoscopy of the time the complated partment and the Relations where conintiated. She also storwarded to the Endoscopy of the time the Endoscopy of the	eft shoulder and stated a nurse repartment told her to breathe ched her really hard causing was angry and upset. A visual inspection of the received the received the received the remance Improvement Concern 10, documented Patient a letter to Patient #33 to received a received by a reformance Improvement of Patient #33. Patient #33 recknowledgement letter within the grievance as required by a reformance Improvement of indicated the grievance had will to a staff member who was read reviewer. The received of received a received received received received in the received in one the received in one time it arrived with Patient replaint investigations were stated the complaint had been doscopy Department for view and they had not heard	A 123	Action Plan Implementation Management Council education regarding Patin Rights and Grievances. on June 17, 2010 Medical Executive Compupdate regarding Patient Rights and Grievances. on June 22, 2010 OAPI Integration: PI Council received report regarding Patient Grievances. Held on June 16, 2010 Nursing Leadership Courreceived report regarding Patient Grievances. Held June 28, 2010 Quality Committee of the Board received annual regarding Patient Grievances. Held on July 6, 2010	ent Held mittee Held ort nces. ncil d on	

15/ 62

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STELLKES REGIONAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZP CODE 190 LAST PARHOCK STREET SOURCE, CONTRIBUTION OF LIST DEPICIENCIES (EACH DEPICION MUST BE PRECEDED BY FULL PRIETY TAG (EACH DEPICION MUST BE PRECEDED BY FULL REGULATION OF USO IDENTIFYING INFORMATION) PRIETY TAG (EACH DEPICION MUST BE PRECEDED BY FULL REGULATION OF USO IDENTIFYING INFORMATION) PRIETY TAG (EACH DEPICION MUST BE PRECEDED BY FULL REGULATION OF USO IDENTIFYING INFORMATION) PRIETY TAG (EACH DEPICION MUST BE PRECEDED BY FULL REGULATION OF USO IDENTIFYING INFORMATION) PRIETY TAG (EACH DEPICION MUST BE PROVIDED TO THE APPROPRIATE COMMETTED TO THE APPROPRIA	STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A, BUILI	ILTIPLE CONSTRUCTION	(X3) DATE S	URVEY
STILUKES REGIONAL MEDICAL CENTER STILUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL PRECEDIATORY OR ISS IDENTIFYING INFORMATION) A 123 Continued From page 5 Patient #33 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiating in heapital policy. b. Patient #31 was a 27-year-old female who came to the ED on 2/15/10. A hospital email communication, dated 2/16/10, indicated the patient's husband complained the ED had given his wife some pills that led to hemorrhaging and subsequent surgery. A Performance Improvement Concern Report, dated 2/23/10, indicated Patient Relations received the complaint and sent an acknowledgement letter within 7 days of initiating the grievance as required by hospital policy. Patient #31 did not receive an acknowledgement letter within 7 days of initiating the grievance as required by hospital policy. Patient Relations Notes, on the same form, indicated Patient Relations Notes, on the same form, indicated Patient Relations Roles, on the same form, indicated Patient Relations Notes, on the same form, indicated Patient Relations Roles, on the same form, indicated Patient Relations Notes, on the same form, indicated Patient Relations Notes, on the same form, indicated Patient Relations requested an update on 5/25/10 from the leaf reviewer to determine the status of the investigation of 116 days after the initial complaint was received. During an interview on 6/07/10 at 3:20 PM, the Director of Nursing Administration reviewed the grievance file information and confirmed the delay			130006	s. wind	3	I	-
PREFIX TAG A 123 Continued From page 5 Patient #33 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation as stated in hospital policy. b. Patient #31 was a 27-year-old female who came to the ED on 2/15/10. A hospital email communication, dated 2/16/10, indicated the patient's husband complained the ED had given his wife some pills that led to hemorrhaging and subsequent surgery. A Performance Improvement Concern Report, dated 2/23/10, indicated Patient Relations received the complaint was filed). Patient #31 did not receive an acknowledgement letter within 7 days of initiating the grievance as required by hospital policy. Patient Relations Notes, on the same form, indicated the complaint was sent for review? on 4/12/10 to a staff member who was assigned to be a lead reviewer. This was 62 days after the complaint had been investigated or a letter of response had been sent as of 6/03/10, a total of 116 days after the initial complaint was received. During an interview on 6/07/10 at 3:20 PM, the Director of Nursing Administration reviewed the grievance file information and confirmed the delay	',,,,,,		AL CENTER		190 EAST BANNOCK STREET		
Patient #33 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation as stated in hospital policy. b. Patient #31 was a 27-year-old female who came to the ED on 2/15/10. A hospital email communication, dated 2/16/10, indicated the patient's husband complained the ED had given his wife some pills that led to hernorrhaging and subsequent surgery. A Performance Improvement Concern Report, dated 2/23/10, indicated Patient Relations received the complaint and sent an acknowledgment to the complainant on 3/04/10 (23 days after the initial complaint was filed). Patient #31 did not receive an acknowledgment letter within 7 days of initiating the greivance as required by hospital policy. Patient Relations Notes, on the same form, indicated the complaint was self for review" on 4/12/10 to a staff member who was assigned to be a lead reviewer. This was 62 days after the complaint was initiated. The form further indicated Patient Relations requested an update on 5/25/10 from the lead reviewer to determine the status of the investigation. No additional information was present in the grievance file to indicate the complaint had been investigated or a letter of response had been sent as of 6/08/10, a total of 116 days after the initial complaint was received. During an interview on 6/07/10 at 3:20 PM, the Director of Nursing Administration reviewed the grievance file information and confirmed the delay	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
		Patient #33 did not hospital's decision in 30 days of initiation b. Patient #31 was came to the ED on communication, dai patient's husband of his wife some pills to subsequent surgery. A Performance Impidated 2/23/10, indicated 2/23/10, indicated 2/23/10, indicated 2/23/10, indicated the complication of the complication of the same was "sent for review member who was a This was 62 days at initiated. The form Relations requested the lead reviewer to investigation. No additional information of the same of 6/08/10, a total complaint was received the lead reviewer to investigated or a let as of 6/08/10, a total complaint was received the information of the same of the sam	receive written notice of the regarding her grievance with as stated in hospital policy. a 27-year-old female who 2/15/10. A hospital email ted 2/16/10, indicated the complained the ED had given that led to hemorrhaging and /. provement Concern Report, stated Patient Relations and sent an the complainant on 3/04/10 nitial complaint was filed). The receive an acknowledgement of initiating the greivance as policy. Patient Relations form, indicated the complaint // on 4/12/10 to a staff ssigned to be a lead reviewer. The form indicated Patient an update on 5/25/10 from determine the status of the status of the determine the status of the complaint had been ter of response had been sent all of 116 days after the initial ved. on 6/07/10 at 3:20 PM, the Administration reviewed the station and confirmed the delay	A 12	✓ Implementation of an tool and reporting pr (through August 31, the following metrics Percent of unresolve grievances > 30 days Percent of patients in writing if the invesinto their grievance v	a audit ocess 2010) for s: 1) d and 2) formed stigation	

FORM CMS-2567(02-99) Previous Versione Obsolete

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 6 of 53

	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER;	, ,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		A. BUILDIN		(c
	130006	D, W1140		06/10	0/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CE	ENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	FBE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPA DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
was first received in Pati- before being forwarded to did not realize until that in hospital had reached a fithe complainants. She a not yet been written and Patient #31 did not received hospital's decision regard 30 days of initiation, as site. c. Patient #27 was a 73- seen in the ED on 4/15/1 communication received dated 4/28/10, indicated falling while getting into a on 4/15/10. Patient #27	/08/10 at 8:00 AM, the tions stated the complaint ent Financial Services to Patient Relations. She morning (6/08/10) the inancial resolution with acknowledged a letter had sent to Patient #31. ve written notice of the ding her grievance with stated in hospital policy. year-old male who was 10. An email in Patient Relations, Patient #27 had reported a cab after leaving the ED reported having had as upset with ED staff for heelchair. His leg was subsequently became ment Concern Report, ted Patient Relations rievance, mailed an to Patient #27, and shysician and additional noce. ations note, dated thad been made for an on. An email response the lead reviewer, dated	A 123			

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER B. WING OF MANUAL MEDICAL CENTER B. WING OF MANUAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712	STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES PRIEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 123 Continued From page 7 follow-up email, dated 6/08/10, indicated Patient Relations made another attempt to contact the lead reviewer to see if the investigation was complete. As of 6/08/10, the grievance file did not contain evidence the hospital had completed an Investigation and sent a written reply to Patient #27. This represented a period of no less than 38 days from the date the complaint was initiated. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations confirmed the investigation had not been completed and a letter of resolution had, therefore, not been sent. She explained, Patient Relations had not heard back from the ED Director who was investigating the complaint. Patient #27 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation, as stated in hospital policy. d. Patient #30 was a 68-year-old male admitted 4/19/10 and discharged 4/26/10. A Performance			130006				1	_
FREERY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 123 Continued From page 7 follow-up email, dated 6/08/10, indicated Patient Relations made another attempt to contact the lead reviewer to see if the investigation was complete. As of 6/08/10, the grievance file did not contain evidence the hospital had completed an investigation and sent a written reply to Patient #27. This represented a period of no less than 38 days from the date the complaint was initiated. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations confirmed the investigation had not been completed and a letter of resolution had, therefore, not been sent. She explained, Patient Relations had not heard back from the ED Director who was investigating the complaint. Patient #27 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation, as stated in hospital policy. d. Patient #30 was a 68-year-old male admitted 4/19/10 and discharged 4/26/10. A Performance			<u> </u>		1	90 EAST BANNOCK STREET	1 00/11	0/2010
follow-up email, dated 6/08/10, indicated Patient Relations made another attempt to contact the lead reviewer to see if the investigation was complete. As of 6/08/10, the grievance file did not contain evidence the hospital had completed an Investigation and sent a written reply to Patient #27. This represented a period of no less than 38 days from the date the complaint was initiated. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations confirmed the investigation had not been completed and a letter of resolution had, therefore, not been sent. She explained, Patient Relations had not heard back from the ED Director who was investigating the complaint. Patient #27 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation, as stated in hospital policy. d. Patient #30 was a 68-year-old male admitted 4/19/10 and discharged 4/26/10. A Performance	PAÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULD BE	(X5) COMPLETION DATE
an RN, documented the family had reported multiple concerns regarding medical and nursing care issues. A Performance Improvement Concern Report, dated 4/28/10, indicated Patient Relations sent the complainant a card to acknowledge the complaint and then forwarded the complaint for review to a staff member who was assigned to be a lead reviewer. An email from hospital staff, dated 5/10/10, documented the investigation was complete. The		follow-up email, data Relations made and lead reviewer to secomplete. As of 6/08/10, the gevidence the hospit Investigation and set Investigation and set Investigation and set Investigation and set Investigation had not get Investigation had, the explained, Patient From the ED Director complaint. Patient #27 did not hospital's decision of 30 days of initiation, d. Patient #30 was 4/19/10 and dischar improvement Event an RN, documented multiple concerns recare issues. A Performance Implicated 4/28/10, indicated 4/28/10	ted 6/08/10, indicated Patient other attempt to contact the er if the investigation was prievance file did not contain all had completed an ent a written reply to Patient ted a period of no less than 38 the complaint was initiated. on 6/08/10 at 8:00 AM, the Relations confirmed the extrement completed and a letter rerefore, not been sent. She relations had not heard back or who was investigating the receive written notice of the regarding her grievance with as stated in hospital policy. a 68-year-old male admitted ged 4/26/10. A Performance, dated 4/28/10, completed by ithe family had reported regarding medical and nursing rovement Concern Report, ated Patient Relations sent and to acknowledge the forwarded the complaint for mber who was assigned to be tai staff, dated 5/10/10,	A	123			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 8 of 53

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
	130006	B. WI	∤G		06/10)/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDIC	CAL CENTER		18	EET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET OISE, ID 83712		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲĻD BE	(X5) COMPLETION DATE
evidence, as of 6/0 been sent a written resolution of the grafter the initial command of the grafter the initial command of the grafter the initial command of Patient investigation was of to be sent but had Patient #30 did not hospital's decision 30 days of initiation 2. A hospital document of Patient Relations, the Relations Quarterly quarter [Septembe 31] and 2nd quarter March 31]), dated a facing the Department including: 1) an incurrence of Patient loss of one position received requiring a additional support. During an interview Director of Nursing responses to grieve in the above reference staffing issues. She position and an emalso, there had been decided in the patient of Patient wanager of Patient manager of Patient manager of Patient manager of Patient manager of Patient patient manager of	reviewed. There was no 18/10, the complainant had a response regarding the levance. This was 41 days plaint was received. Yon 6/08/10 at 8:00 AM, the tale and the letter was due	A	123			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 9 of 53

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		PLE CONSTRUCTION	CONSTRUCTION (X3) DATE SURVE COMPLETED		
			A, BU		<u></u>	, ,		
		130006	B, WI	- co		06/10/2010		
	ROVIDER OR SUPPLIER S REGIONAL MEDIC	AL CENTER		19	BEET ADDRESS, CITY, STATE, ZIP CODE BO EAST BANNOCK STREET BOISE, ID 83712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 129	quarters they had macknowledged that beginning April 1, the probably because the since 4/07/10 and a also stated it had be responses from depto investigate computed departments were with the stated complaint was growing, and the follow-through with the hospital failed the respond to complaint day timeframe as stated to complaint the hospital failed to telephone for 2 of 9 psychiatric records and hospital the ability of patients resulted in a violation findings include: 1. Patient #16 was admitted to the hosp self-reported medical control of the complaint of the co	thin 30 days. In previous the or exceeded this goal. She during the current quarter, they had gotten behind, they had been down one staff another staff had been ill. She can difficult at times to get partments who were assigned laints. She stated the very busy and had a hard time into have staff from the Patient and have staff from the Patient and have staff for the hospital ney lacked staff for complaints. To investigate, resolve, and mants in writing within the 30 ated in hospital policy. RIGHTS: EXERCISE OF		123				

NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEPICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 199 EAST BANNOCK STREET BOISE, ID 83712 PRIEFIX SUMMARY STATEMENT OF DEPICIENCIES PROVIDERS PLAN OF CORRECTION TAND		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DESCRIPTIONS SUMMARY STATEMENT OF DESCRIPTIONS OF SUMMARY STATEMENT OF SUMMARY STATEMENT OF DESCRIPTIONS OF SUMMARY STATEMENT OF SUMMARY ST							(:
ST LUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEPOISENCES PROVIDERS PLAN OF CORRECTION			130005	B. WI	, w		06/10	0/2010
A 129 Continued From page 10 and was assigned a 1:1 sitter. Patient #16's record contained a nursing note, dated 4/26/10 at 12:16 PM, which stated Patient #16 reduced to give the cell phone to the staff and was intructed that if she did not cooperate and give up the cell phone, to be placed in restraints. The hospital's policy tiltled Care of Patients with Threatened or Actual Sucide Attempt, dated 4/12/09, stated staff would remove any items from the room that could potentially be used for self-harm. The policy referred to the hospital's Safety Checklist, that was not dated, instructed staff to remove telephone cords from the room and store them in a locked cupboard. Neither the policy, nor the checklist, provided direction to staff as to how to accommodate the patient's desire or need for a telephone. 2. Patient #17 was a 63-year-old female, admitted to the hospital on 1/07/10, after a self-reported overdose. Patient #17's record documented she was on a suicide watch and had a 1:1 sitter. A nursing shift note, dated 1/11/10 from 3:00 PM to 8:00 PM, stated Patient #17 was talking on the phone. The Clinical Supervisor of the Medical floor, was interviewed on 6:00/10 starting at 12:05 PM. He stated Patient #17 did have a cell phone during most of her hospital stay. He stated that this was an oversight and when it was identified that Patient #17 had a cell phone, the phone was removed from her prossession. The stated that this was an oversight and when it was identified that Patient #17 had a cell phone, the phone was removed from her prossession. The patient will be supervised for safety reasons, a phone is to be made available upon patient request. The patient will be supervised while using the phone." Finalized June 11, 2010. Update of the Suicide Precautions Checklist to include the following instructions, "The patient is to be informed they should contact the RN if they wish to cont			AL CENTER		1	90 EAST BANNOCK STREET		
and was assigned a 1:1 sitter. Patient #16's record contained a nursing note, dated 4/26/10 at 12:16 PM, which stated Patient #16 had a cell phone which the staff attempted to remove from her possession. The note documented that Patient #16 refused to give the cell phone to the staff and was instructed that if she did not cooperate and give up the cell phone, she would be placed in restraints. The hospital's policy titlled Care of Patients with Threatened or Actual Suicide Attempt, dated 4/12/09, stated staff would remove any items from the room that could potentially be used for self-harm. The policy referred to the hospital's Safety Checklist, that was not dated, instructed staff to remove telephone cords from the room and store them in a locked cupboard. Neither the policy, nor the checklist, provided direction to staff as to how to accommodate the patient's desire or need for a telephone. 2. Patient #17 was a 63-year-old female, admitted to the hospital on 1/07/10, after a self-reported overdose. Patient #17's record documented she was on a suicide watch and had a 1:1 sitter. A nursing shift note, dated 1/11/10 from 3:00 PM to 8:00 PM, stated Patient #17 was talking on the phone. The Clinical Social Scrvices Process Improvements: V Update of the Suicide Precautions policy with the following statement: "If the telephone is removed from the room or locked in a secure cupboard for safety reasons, a phone is to be made available upon patient will be supervised while using the phone." Finalized June 11, 2010. V Update of the Suicide Precautions policy with the following statement: "If the telephone is removed from the room or locked in a secure cupboard for safety reasons, a phone is to be made available upon patient will be supervised while using the phone." Finalized June 11, 2010. V Update of the Suicide Precautions policy with the following instructions, "The patient is to include the following instructions," The patient is to be informed they should contact the RN if they wish to contact the RN if th	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
patients who were on suicide watch were not Finalized June 28, 2010.	A 129	and was assigned a record contained a 12:16 PM, which staphone which the state her possession. The Patient #16 refused staff and was Instructed cooperate and give be placed in restrain. The hospital's policy Threatened or Actual 4/12/09, stated staff from the room that contains the policy Safety Checklist. The policy Checklist. The policy Checklist. The policy Checklist was not dated, telephone cords from a locked cupboard. Checklist, provided contains a commodate the properties of the policy self-reported overded documented she was a 1:1 sitter. A nursing from 3:00 PM to 8:0 talking on the phone. The Clinical Superviolating on the phone of the contains an oversight and when the patient #17 and a commoved from her patient #17 had a commove	a 1:1 sitter. Patient #16's nursing note, dated 4/26/10 at ated Patient #16 had a cell aff attempted to remove from he note documented that it to give the cell phone to the cted that if she did not up the cell phone, she would not. y tittled Care of Patients with all Suicide Attempt, dated if would remove any items could potentially be used for cy referred to the hospital's he hospital's Safety Checklist, instructed staff to remove in the room and store them in Neither the policy, nor the direction to staff as to how to eatlent's desire or need for a as 63-year-old female, of the county of the material of the policy as on a suicide watch and had no shift note, dated 1/11/10 to PM, stated Patient #17 was expected in the stated that this was need it was identified that ell phone, the phone was ossession. He stated that	Α.	129	In response to A-129 Action Plan Responsible Par Tom Aronson, MBA, LCSW director of Clinical Social Services Process Improvements: Update of the Suicide Precautions policy with the following statement: "If telephone is removed from room or locked in a secun cupboard for safety reason phone is to be made avain upon patient request. The patient will be supervised while using the phone." Finalized June 11, 2010. Update of the Suicide Precautions Checklist to include the following instructions, "The patient be informed they should contact the RN if they will contact someone outside hospital and reasonable ewill be made to accommiss the patient's wishes. The patient will be supervised safety while using	the the on the re ons, a lable le d	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

21/ 62

PRINTED: 06/29/2010 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 130006 06/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID PREFIX (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 129 Continued From page 11 A 129 In response to A-129 cont... allowed a telephone. The hospital's Social Service Supervisor was ✓ The medical record for interviewed on 6/08/10 starting at 10:35 AM. He patients on suicide precautions stated that patients on suicide watch did not have will be reviewed during a telephone in their room. He was unsure as to rounds by the Nursing how staff was to allow patients to use the phone. Administrative Supervisor, Patient #17's physician was interviewed on Charge Nurse, or Social 6/08/10 starting at 1:00 PM. She stated that Work. Initiated by August 31. Patient #17 did have a cell phone during most of 2010. her hospital stay. She also indicated this was an oversight and when it was identified that Patient #17 had a cell phone, the phone was removed Action Plan Implementation: from her possession. She was unsure as to how Policy changes communicated staff were to allow patients to use the phone or if to the Interdisciplinary they were even allowed to use one. Clinical Education Team and Patient #17's telephone use was restricted due to Clinical Education Service her status of being on suicide watch. Team. Communicated on June 16, 2010 Staff were interviewed regarding their ✓ Policy changes communicated understanding of patients'use of telephones while on suicide watch. to the Nursing Education Council. Communicated on Staff N. an RN, was interviewed on 6/08/10 July 6, 2010. starting at 2:23 PM. She stated that patients on suicide watch did not have a telephone in their

FORM CMS-2567(02-99) Previous Versions Obsolete

phone.

room and were not allowed to use a telephone.

Staff P, a RN, was interviewed on 6/08/10 starting

at 2:43 PM. She stated that patients on suicide

she did not know how patients were to use the

watch did not have a telephone in their room and

A RN was interviewed on 6/08/10 starting at 2:25

PM. She stated it was up to the nurse as to

whether patients on suicide watch could use a

Event ID: 7EK211

Facility ID: ID1LGZ

telephone

OAPI Integration:

Implementation of an audit

Percent of nurses caring for

(through August 31, 2010) for

patients on suicide precautions

who report informing them of

tool and reporting process

the following metric: 1)

their right to access the

if continuation sheet Page 12 of 5

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI		"	(c
		130006	B. Wir	4G		06/14	0/2010
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 129	Continued From partelephone. A CNA was interviee 2:07 PM. She state whether patients on telephone. Hospital staff were at to promote and protect to promote and protect to promote and practice 482.13(b)(2) PATIECONSENT The patient or his or allowed under State informed decisions of the health status, planning and treatment construed as a mecoprovision of treatment medically unnecessary. This STANDARD is Based on staff interview and hospital failed to patients (#2 and #14.	ge 12 wed on 6/08/10 starting at dit was up to the nurse as to suicide watch could use a not sufficiently trained on how ect the rights of each patient. o promote patient rights in its es related to telephone use. NT RIGHTS: INFORMED Ther representative (as law) has the right to make regarding his or her care. Include being informed of his being involved in care ent, and being able to request This right must not be hanlsm to demand the nt or services deemed	TAG	129	CROSS-REFERENCED TO THE APPR		
	protected by allowing decisions regarding patients being place	g them to participate in their care. This resulted in 2 d on involuntary holds for the for discharge planning					

Event ID: 7EX211

Facility ID: ID1LGZ

If continuation sheet Page 13 of 53

NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER DISE, ID 83712 A 131 Continued From page 13 Ideho statute 66-326 states a "person may be detained at a hospital at which the person presented or was brought to receive medical or mental health ear, if the peace officer or a physician medical staff member of such hospital has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to themselves or others, as evidenced by a threat of substantial physicial harm. "Two patients (82 and #14) were placed on involuntary holds without an evaluation by a physician that their confinued liberty posed an imminent danger to themselves or others. Examples include: 1. Patient #2's medical record documented an 81-year-old female who was admitted to the hospital on 30/61/10 and was discharged on 3/05/10. She presented to the emergency department on 3/04/10 at 04-86 PM. A History and Physicial clicated at 12-43 AM on 3/05/10, stated Patient #2 had fallen and suffered a contusion of her forehead and laceration of her nose which required suturing. The report stated she had returned later and been treated for confusion related to dehydration. She was rehydrated and sent home again before returning a third time. The report stated Patient #2 had fallent. The report stated of the person higher the hospital. "The report stated Patient #2 had fallent person higher the hospital." The report stated Patient #2 had a history of "depression with possibly some psychotic features" The report stated Patient #2 had a history of "depression with possibly some psychotic features" The report stated Patient #2 had a history of "depression with possibly some psychotic features" The report stated be person, place,		Î OF DEFICIENÇIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
STLUKES REGIONAL MEDICAL CENTER ST LUKES REGIONAL MEDICAL CENTER STULKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES FREED BY PULL PRICE ACM DEFICIONY MUST BE PRECEDED BY PULL PRICE ACM DEFICIENCY MUST BE PRECEDED BY PULL PRICE ACM DEFICIONY MUST BE PRECED BY PULL PRICE ACM DEFICIONY MUST BE PRECEDED BY PULL PRICE ACM DEFICIONY MUST BE PRECEDED BY PULL PRICE ACM DEFICIONY MUST BE PRICE ACM DEFICIONY MUST BE PLAN OF CORRECTION COMPLTIONY PARK TAGE BY PLAN OF CORRECTION COMPLTIONY PRICE ACM DEFICIONY MUST BY PLAN OF CORRECTION COMPLTIONY PROVIDED BE CONSTRUCTION OF THE APPROPRIATE COMPLTANT TAGE A 131 In response to A-131 Action Plan Responsible Party: Tom Aronson, MBA, LCSW, director of Clinical Social Services Process Improvements: Y Immediate process change where Social Work leadership would be notified of all patients being placed by a physician on an involuntary mental health hold. Implemented June 11, 2010 Education of Emergency Medicine of Idaho physicians and St. Luke's Internal Medicine Of Idaho physicians and St. Luke's Inter			130006					
A 131 Continued From page 13 idaho statute 66-326 states a "person may be detained at a hospital at which the person presented or was brought to receive medical or mental health care, if the peace officer or a physician medical staff member of such hospital has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm" Two patients (#2 and #14) were placed on involuntary holds without an evaluation by a physician that their continued liberty posed an imminent danger to themselves or others. Examples include: 1. Patient #2's medical record documented an 81-year-old female who was admitted to the hospital on 3/04/10 and was discharged on 3/05/10. She prosented to the emergency department on 3/04/10 at 9/45 PM. A History and Physicial dictated at 12/43 AM on 3/05/10, stated Patient #2 had fallen and suffered a contusion of her forehead and laceration of her nose which required sutring. The report stated Patient #2 thought she had slipped and fallen. The report stated she had been treated for confusion related to dehydration. She was rehydrated and sent home again before returning a third time. The report stated Patient #2 had a history of "depression with possibly some psychotic features" The report stated Patient #2 had a history of "depression with possibly some psychotic features" The report stated her affect					1:	90 EAST BANNOCK STREET	100/1	
Idaho statute 66-326 states a "person may be detained at a hospital at which the person presented or was brought to receive medical or mental health care, if the peace officer or a physician medical staff member of such hospital has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm." Two patients (#2 and #14) were placed on involuntary holds without an evaluation by a physician that their continued liberty posed an imminent danger to themselves or others. Examples include: 1. Patient #2's medical record documented an 81-year-old female who was admitted to the hospital on 3/04/10 and was discharged on 3/05/10. She presented to the emergency department on 3/04/10 and was discharged on 9/05/10. She presented to the emergency department on 3/04/10 and was discharged on 19/05/10, stated Patient #2 had fallen and sulfered a contusion of her forehead and laceration of her nose which required suturing. The report stated Patient #2 thought she had been seen first for a urinary tract infection and confusion. The report stated she had returned later and been treated for confusion related to dehydration. She was rehydrated and sent home again before returning a third time. The report stated and sent home again before returning a third time. The report stated beauto sent pen treated for confusion related to dehydration. She was rehydrated and sent home again before returning a third time. The report stated beauto sent pen to the impression that she is markedly depressed as well as somewhat paranold and concerned about being here in the hospital." The report stated her affect the impression that he is markedly depressed as well as somewhat paranold and concerned about being here in the hospital." The report stated her affect the impression that she is markedly depressed as well as somewhat paranold and concerned about being here in the hospital." The report stat	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BĒ	COMPLETION
		Idaho statute 66-32 detained at a hospit presented or was be mental health care, physician medical shas reason to believe disabled due to mercontinued liberty pot that person or other substantial physicial and #14) were place without an evaluation continued liberty pot themselves or other 1. Patient #2's med 81-year-old female hospital on 3/04/10 3/05/10. She presed department on 3/04/10 3/05/10. She presed department on 3/04 Physicial dictated at Patient #2 had faller her forehead and la required suturing. It thought she had slip stated this was her infection and confus had returned later a related to dehydratic sent home again be The report stated "I markedly depressed paranoid and conce hospital." The report instory of "depress psychotic features	if states a "person may be tal at which the person rought to receive medical or if the peace officer or a staff member of such hospital we that the person is gravely intal illness or the person's sees an imminent danger to its, as evidenced by a threat of harm" Two patients (#2 ed on involuntary holds on by a physician that their sed an imminent danger to its. Examples include: Itical record documented an who was admitted to the and was discharged on inted to the emergency 10 at 9:45 PM. A History and it 12:43 AM on 3/05/10, stated in and suffered a contusion of ceration of her nose which the report stated Patient #2 oped and fallen. The report stated she in seen first for a urinary traction. The report stated she ind been treated for confusion on. She was rehydrated and fore returning a third time, get the impression that she is it as well as somewhat rined about being here in the it stated Patient #2 had a sion with possibly some "The report stated her affect"	A .	131	Action Plan Responsible Par Tom Aronson, MBA, LCSW director of Clinical Social Services Process Improvements: Immediate process chang where Social Work leade would be notified of all patients being placed by a physician on an involunta mental health hold. Implemented June 11, 20 Education of Emergency Medicine of Idaho physic and St. Luke's Internal Medicine Hospitalists regarding criteria for involuntary mental health placement. Communicat sent by July 7, 2010. The medical record for patients on mental health holds will be reviewed du rounds by the Nursing Administrative Superviso Charge Nurse, or Social Work. Initiated by Augu	ge rship a ary 10 cians hold ions aring	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1	ULTIPL LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		B. WIN		м.		- 4
	130006	1, 7 - 7			06/10	/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL C	CENTER		190	ET ADDRESS, CITY, STATE, ZIP CODE DEAST BANNOCK STREET DISE, ID 83712		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ULD BE	(X6) COMPLETION DATE
not appear to be in any The report stated the pl for hydration and "pos psychiatric evaluation a geriatric psychiatric hos evaluation and adjustme The next physician note 3:00 PM. The entire no distress. Refused trans psychiatric hospital]. W "I'm doing horrible. I wil arrangements rather that psychiatric debility were geriatric psychiatric hos Patient #2's psychiatric documented in the med description of Patient #2 she was a danger to he documented. The RN documented on Flowsheet Report section medical record, at 10:44 the heading Psycho-Soc software prompted "Agil answered "Yes." No oth #2's agitation or descrip documented. This was medical record by a nur- Patient #2. A note docu discharge and condition discharge was not press A tracking document fro dispatch, labeled Transf Patient #2 was transpor	ilso stated Patient #2 did v distress but was tearful. Ilan was to admit Patient #2 ssible consideration of a and maybe transferred to [a spital] for medication nent." e was dated 3/05/10 at bite stated "Pt alert in no sfer to [the geriatric when trying to discuss says ill make other an go to [the geriatric orders including hold for a signed. Transfer to [the spital] ." No evaluation of condition was dical record. No 2's behavior that indicated erself or others was In the Cumulative on of the electronic 4 AM on 3/05/10. Under cial Assessment, the litated," to which the nurse ther indication of Patient otion of her behavior was the last note in the rse who provided care to umenting the time of n of the patient at ent in the medical record, om the ambulance	Α.	131	In response to A-131 con Implementation of a check to be used when placing a patient on an involuntary mental health hold. Implement by August 31, 2010. Action Plan Implementation: Face-to-face education for social workers was held to review involuntary mental hold policies, including documentation requirementation requirementation regarding involuntary mental health holds. Held on June 17, 2 Medical Executive Communication regarding involuntary mental health holds. Held on June 17, 2 Medical Executive Communication regarding involuntary mental health holds. Held June 22, 2010 Nursing Administrative Supervisor update regarding involuntary mental health holds. Held on July 7, 20	klist a c c c c c c c c c c c c	

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130006	p, wit	NG _		06/10	0/2010
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER	•	19	EET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET OISE, ID 83712	A	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 131	Continued From pa	ge 15	Α.	131	In response to A-131 cor	1t	,
	3/05/10 at 11:55 AM Manager, met with The note said they possibility of dischar psychiatric hospital currently lived in an there. The note staunsure if she will go hospital) voluntarily No behavior was do #2 was a danger to disabled. A Social Service As 12:18 PM on 3/05/1 The assessment quitable with the same that the same to meet bas Understand Progno Adequate Family Stadequate Social Surveyors. The Social Service Service Focus Note the same time. The Worker met with Pa	Issues Patient Patient sions Patient ss Patient zation Yes questions Yes sic needs Yes sis Yes upport Yes			OAPI Integration: Implementation of an autool and reporting proces (through August 31, 201 the following metric: 1) Percent compliance with completion of involuntar mental health hold documentation requirem	dit ss 0) for cy	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 16 of 63

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		130006	B. WI			1	C 0/2010
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET BOISE, ID 83712	00/10	JIZO 10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 131	diagnosed with "De ago and had spent hospital in [another stated Patient #2's with medication but in February 2010, s had previously, accordaughter] and her b [appointment] with a file for legal guardia arrive tomorrow. The and withdrawn. She SWSW called [the regarding not know medical POA for the out once the pt is the pt in. If the pt attem the POA would need discussed with the corlierla for a hold for attending MD wante. It stated the for care by the physical paper work receiving hospital. A discharge of Patient discharge, the mode condition of the patie present in the record A specific assessment state or behavior wastay. The specific be	lusional Disorder a few years 3 weeks in a psychlatric state]." The Focus Note symptoms had been controlled, after a change of medication he "has not presented as she ording to [the daughter][The rother have an appt an attorney next Tuesday to nship of their mother. He will be pt presented as very flat edid not want to talk to e geriatric psychiatric hospital] ng who, if anyone, may have be pt. They can help work this ere and the daughter can sign pts to leave, however, then do to be notified. SW case mgr about the pt meeting being gravely disabled if the do pursue that route." medical record was dated The note was by the social expatient had been accepted ician at the geriatric. It stated "Transport notified" was being prepared for the anote documenting the #2, including the time of of transport, and the ent at discharge, was not	A	131			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID: IQ1LGZ

If continuation sheet Page 17 of 53

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130006	B, Wir	۱Ģ _		05/10)/2010
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 131	dated 3/05/10 at 1:3 and filed with the cobeen on a steady madaughter. The apply previous psychiatric having paranoid the Patient #2 was not so f self-care, had a f talk much today. The specific behavioral hold. Patient #2's Interdist Plan, dated 3/04/10 plan related to her bissues. The Patient stated "Pt will be abself-care." No plan Staff B, Patient #2's interviewed on 6/08 asked what specific	Commitment of the Mentally III, 31 PM, signed by the physician burt, stated Patient #2 had been bughts. The application stated able to complete her activities lat affect, and did not want to he application did not state a reason for the involuntary. Iciplinary Care Management and 3/05/10, did not contain a behavior or psychological to Focus List, part of the plan, alle to verbalize needs for for this was documented. Social Worker, was 10.30 AM. Staff B was behavior Patient #2 exhibited	A	131			
	Staff B could not stanot assess Patient apsychological status patient was placed or replied Patient #2 control activities of daily living diagnosis. Staff D, the physicial hold, was interviewed She stated Patient #2 physician. She said that Patient #2 needs	er on an involuntary hold. ate one. She stated she did #2's mental status or by When asked why the on an involuntary hold, she ould not take care of her and had a mental health an who signed the involuntary ad on 6/09/10 at 3:05 PM. We was admitted by the on-call she was told by the hospital led to leave, to be transferred, the practice and came to the					

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1	TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
		130006	B. WING	· · · · · · · · · · · · · · · · · · ·	06/10	C 0/2010
	ROVIDER OR SUPPLIER	AL CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(ÉACH DÉFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 131	hospital. Staff D staprobably oriented to said much of her as based on her previo #2 was psychotic be example of the patiesaid Patient #2 was reasoned with. She to be in the hospital transferred to anoth not know if other po #2 had been discus Staff A, the nurse w 3/05/10, was intervi She stated the last documented at 10:4 she did not rememb know what she mea patient was "Agitate chosen from a men medical record. She not documented. Patient #2 was plac without an evaluation the convenience of facilitate discharge patient #14's me 69-year-old male withospital on 2/12/10. 2/15/10. Diagnoses homosexual delusion involuntary hold was The discharge summer the said was the s	ated Patient #2 was alert and operson, place, and time. She sessment of Patient #2 was ous history. She stated Patient but she did not have a specific ent's psychotic behavior. She angry and could not be a said Patient #2 did not want and did not want to be ser hospital. She said she did easible placements for Patient sed. The cared for Patient #2 on ewed on 6/10/10 at 9:20 AM. nursing care note was 14 AM on 3/05/10. She stated for Patient #2 and did not eat when she documented the ed." She stated this term was u of choices in the electronic e stated a discharge note was ed on an involuntary hold on of her mental status and for hospital staff in order to planning. Idical record documented a no was admitted to the and was discharged on a included dementia, on, and diabetes. An a documented on 2/15/10. The provided demential of the documented on 2/15/10. The provided demential of the documented on 2/15/10, stated on the planning of the planni	A 131			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID;7EK211

Facility ID: ID1LGZ

If continuation sheet Page 19 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/29/2010 FORM APPROVED

STATEMENT OF DESIGLENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 130006 INAME OF PROVIDER OR SUPPLIER STLUKES REGIONAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST SANNOCK STREET BOISE, ID 89712 POUR REGULATORY OR LISC IDENTIFYING INFORMATION) A 131 Continued From page 19 [discharge] plan had been that the patient move from his home setting to an assisted living facility. We were having difficulty finding that due to these debusions, and instead he was transferred to behavioral health." The discharge summany did not state that Patient #14 had dementia and his symptoms had been worsening over the past several months. The record stated the patient had answered the door naked and had spoken on the telephone to a family member of homosexual delusions. A psychiatric examination, dated 2/12/10, stated Patient #14 had a calm affect but described receiving "messages that come from his head" regarding homosexual activities. The note stated Patient #14 had a calm affect but described receiving increase that come from his head" regarding homosexual activities. The note stated Patient #14 had oa calm affect but described receiving increase that come from his head" regarding homosexual activities. The note stated Patient #14 had a calm affect but described receiving increase that come from his head" regarding homosexual activities. The note stated Patient #14 had a calm affect but described receiving increase that come from his head" regarding homosexual activities. The note stated Patient #14 had no complaints. The note stated Patient #14 had no complaints. The note stated Patient #14 had no complaints. The note stated Patient #14 was sexually inappropriate with a male RN hie evening before but there was no "Occus note to support." Patient #14 was described as "Aler and oriented to hospitalPlantAwait ALF placement." A physician Progress Note, dated 2/13/10 at 34-54 AM, stated Patient #14 was sitting in the hallway with a first. The note stated Patient #14 was sitting in the hallway	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-031							0938-0391
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 89712 PROVIDER OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) A 131 Continued From page 19 [discharge] plan had been that the patient move from his home setting to an assisted living facility. We were having difficulty finding that due to these delusions, and instead he was transferred to behavioral health." The discharge summary did not state that Patient #14 was placed on an involuntary hold or the reasoning behind that decision. The Emergency Department record, dated 2/12/10, stated Patient #14 had dementia and his symptoms had been worsening over the past several months. The record stated the patient had answered the door naked and had spoken on the telephone to a family member of hornosexual delusions. A psychiatric examination, dated 2/12/10 at 1052 PM, stated Patient #14 had a calm affect but described receiving "messages that come from his head" regarding homosexual activities. The note stated Patient #14 denied wanting to harm himself or others. A physician Progress Note, dated 2/13/10 at 12-45 PM, stated "Plan 1. Not safe for discharge to live alone. Must find appropriate ALF. Discussed [with] patient & son at bedside-both agreeable." A physician Progress Note, dated 2/14/10 at 11-45 AM, stated Patient #14 had no complaints. The note stated Patient #14 was sexually inappropriate with a male RN the evening before but there was no "focus note to support." Patient #14 was described as "Alert and oriented to hospitalPlan:Await ALF placement." A physician Progress Note, dated 2/15/10 at 192-945 AM, stated Patient #14 was sitting in the hallway with a sitter. The note stated the			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,				
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER ST LUKES REGIONAL MEDICAL CENTER (AUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY) AND THE PRETEX (EACH DEPICIENCY MUST SEE PRECEDED BY FULL PRETEX (EACH DEPICIENCY MUST SEE PRECEDED BY FULL PRECED BY FULL PRECEDED BY FULL PRECEDED BY FULL PRECEDED BY FULL PRECED BY FULL PRECED BY FULL PRECED BY FULL PRECED BY FULL PRECEDED BY FULL PRECED BY FULL PRECED BY FULL PRECEDED BY FULL PRECEDED BY FULL			130006				1	
ST LUKES REGIONAL MEDICAL CENTER 190 EAST BANNOCK STREET 100 EAST	NAME OF B	IONVINCO AO ÉCODI ICO				THE ADDRESS OF STATE TO COME		JEUIU
A 131 Continued From page 19 (discharge) plan had been that the patient move from his home setting to an assisted living facility. We were having difficulty finding that due to these delusions, and instead he was transferred to behavioral health.* The discharge summary did not state that Patient #14 had dementia and his symptoms had been worsening over the patient had answered the door naked and had spoken on the telephone to a family member of homosexual delusions. A psychiatric examination, dated 2/12/10 at 1052 PM, stated Patient #14 had a calm affect but described receiving "member of homosexual activities." The note stated Patient #14 denied wanting to harm himself or others. A physician Progress Note, dated 2/13/10 at 12:45 PM, stated Patient #14 was sexually inappropriate with a male RN the evening before but there was no "focus note to support." Patient #14 was described as "Alert and oriented to hospitalPlan:Await ALF placement." A physician Progress Note, dated 2/15/10 at 10:54 PM, stated Patient #14 was sexually inappropriate with a male RN the evening before but there was no "focus note to support." Patient #14 was described as "Alert and oriented to hospitalPlan:Await ALF placement." A physician Progress Note, dated 2/15/10 at 10:54 PM, stated Patient #14 was sexually inappropriate with a male RN the evening before but there was no "focus note to support." Patient #14 was described as "Alert and oriented to hospitalPlan:Await ALF placement." A physician Progress Note, dated 2/15/10 at 10:54 PM, stated Patient #14 was sitting in the hallway with a sitter. The note stated he			AL CENTER		1	90 EAST BANNOCK STREET		
[discharge] plan had been that the patient move from his home setting to an assisted living facility. We were having difficulty finding that due to these delusions, and instead he was transferred to behavioral health." The discharge summary did not state that Patient #14 was placed on an involuntary hold or the reasoning behind that decision. The Emergency Department record, dated 2/12/10, stated Patient #14 had dementia and his symptoms had been worsening over the past several months. The record stated the patient had answered the door naked and had spoken on the telephone to a family member of homosexual delusions. A psychiatric examination, dated 2/12/10 at 10:52 PM, stated Patient #14 had a calm affect but described receiving "messages that come from his head" regarding homosexual activities. The note stated Patient #14 denied wanting to harm himself or others. A physician Progress Note, dated 2/13/10 at 12:45 PM, stated "Plan 1. Not safe for discharge to live alone. Must find appropriate ALF. Discussed [with] patient & son at bedside-both agreeable." A physician Progress Note, dated 2/14/10 at 11:45 AM, stated Patient #14 was sexually inappropriate with a male RN the evening before but there was no "focus note to support." Patient #14 was described as "Alert and oriented to hospitalPain:Await ALF placement." A physician Progress Note, dated 2/15/10 at 19:45 AM, stated Patient #14 was sitting in the hallway with a sitter. The note stated he	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD 8E	(XS) COMPLETION DATE
was aware he was in St. Lukes Regional Medical Center and the physician was covering for Patient #14's regular physician. The note stated "He		[discharge] plan har from his home setti We were having dif delusions, and instead behavioral health." not state that Patier involuntary hold or idecision. The Emergency De 2/12/10, stated Pati symptoms had been several months. Thad answered the delusions. A psych 2/12/10 at 10:52 Ph. calm affect but described that come from his lactivities. The note wanting to harm him A physician Progress 12:45 PM, stated "Pto live alone. Must in Discussed [with] paragreeable." A physician Progress 12:45 PM, stated "Pto live alone. Must in Discussed [with] paragreeable." A physician Progress 12:45 PM, stated "Pto live alone. Must in Discussed [with] paragreeable." A physician propria evening before but it support. "Patient #1 and oriented to hosp placement." A physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was aware he was in Center and the physician progress 12:45 AM, in the hallway with a was a ware he was in Center and th	d been that the patient move ng to an assisted living facility. fliculty finding that due to these ead he was transferred to. The discharge summary did nt #14 was placed on an the reasoning behind that the reasoning behind that the reasoning behind that the reasoning behind that the reasoning over the past ne record stated the patient floor naked and had spoken on amily member of homosexual iatric examination, dated the patient #14 had a cribed receiving "messages head" regarding homosexual stated Patient #14 denied inself or others. The Note safe for discharge find appropriate ALF. Itent & son at bedside-both iclan Progress Note, dated the stated Patient #14 was itte with a male RN the there was no "focus note to 14 was described as "Alert bitalPlan:Awalt ALF ician Progress Note, dated stated Patient #14 was sitting is sitter. The note stated he in St. Lukes Regional Medical sician was covering for Patient	A	131			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID; ID1LGZ

If continuation sheet Page 20 of 53

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION ING	(X3) DATE SU COMPLE		
		130005	s. wii	NG _			C 06/10/2010	
- , , ,	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER		١ ٠	TREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DAYÉ	
A 131	A Progress Note by 2/15/10 at 3:50 PM, #14's son and daug Director for the ALF Director had contact hospital and though appropriate for admithe ALF. The note the referral to the githe family was avail corresponding orde 2/15/10 at 4:40 PM, psychiatric hospital discharge him to his physician Progress documented), state patient & he is willing psychiatric hospital 2/15/10 at 5:50 PM, health hold." No proaccompanied the or A Psychological and RN, dated 2/15/10 at 5:50 PM, health hold." No proaccompanied the or documented and not documented. A Psychological and RN, dated 2/15/10 at 5:50 PM, stated "Disorier clarification was documented. A Psychological and courrented. A Psychological and PM, stated "Disorier clarification was documented and not documented. A Psychological problems or others or described disabled.	e to ALF placement." If the Case Manager, dated If, stated she met with Patient If the and the Admissions The note stated the ALF Ited a geriatric psychiatric It Patient #14 would be Itession there before coming to Ite stated the Social Worker sent Iteriatric psychiatric hospital and Itelatric psychiatric #1, to Itelatric psychiatric p	A	131				

;2083812861

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BUI	–	CONSTRUCTION	(X3) DATE SU COMPLE	
		130006	8, WIN			06/10)/2010
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC			190 E	ADDRESS, CITY, STATE, ZIP CODE AST BANNOCK STREET E, ID 83712		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 131	#14 and his son and the ALF represental the geriatric psychiated to the ALF. The nother receiving hospital Note by Staff F, the at 4:45 PM, stated a psychiatric hospital Social Service Foct 2/15/10 at 6:19 PM, Durable Power of A executed 2 days prigeriatric psychiatric placed on a "Physic stated Staff F information of the was a danger of disabled. The final record was a "CM F 6:19 PM. It stated F involuntary hold and him to the receiving is a legal process we custody by the hospital was a focus note stating of Patient #14's Interd Plan, dated 2/13/10 psychological status inappropriate behaviolumn, dated 2/15/Physician hold @ re	ge 21 Istated she met with Patient d daughter. The note stated tive wanted the patient to go to atric hospital prior to admission te stated a referral was sent to al. A Social Service Focus Social Worker, dated 2/15/10 she called the geriatric and beds were available. The us Note by Staff F, dated Istated because Patient #14's storney for Health Care was or to his hospitalization, the hospital wanted Patient #14's pleted an application for note did not include an ent #14's psychological status of specific behaviors to indicate self or others or gravely note in Patient #14's medical focus Note," dated 2/15/10 at Patient #14 was placed on an Ithe family would transport hospital. An involuntary hold here a patient is taken into sital. The note did not explain the time and circumstances charge was not documented. Isciplinary Care Management 1/2/15/10, did not mention or direction to staff regarding iors. A Discharge Planning 10, stated, "Pt placed on quest of Dr. [name], admitting chiatric hospital]. Son,	Α.	31			

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: 7EK211

Facility ID: IO1LGZ

If continuation sheet Page 22 of 53

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER ST LUKES REGIONAL MEDICAL CENTER STRUCKS REGIONAL MEDICAL CENTER SUBJECT OF DESIGNATION OF THE PROCESSOR TO PROPERLY STATE, ZIP COULD SATE BANNOCK STREET BOISE, ID 83712 CONTINUED REGULATORY OR LISCIDENTIFYING INFORMATION) A 131 Continued From page 22 daysight will transport." Staff E, Patient #14's physician, was interviewed on 6/07/10 at 4:25 PM. He stated he did not evaluate Patient #14 prior to placing him on an involuntary hold. He stated he did not evaluate Patient #14's proving logicing him on an involuntary hold. He stated he did not evaluate Patient #14's psychological status, She stated with the psychological status, She stated Patient #14's psychological status, She stated with the psychological status, She stated Patient #14's psychological status, She stated William Wil		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING C		TED		
ST LUKES REGIONAL MEDICAL CENTER CAG-ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PROVIDER'S PLAN OF CORRECTION (MIST BE PRECEDED BY FULL TAGE PROVIDER'S PLAN OF CORRECTION (MIST BE PRECEDED BY FULL TAGE PROVIDER'S PLAN OF CORRECTION (MIST PARK) PROVIDER'S PLAN OF CORRECTION (MIST PARK)			130006	B. WII	NG _	M. Tarris Maria Anna and Anna		
A 131 Continued From page 22 daughter will transport." Staff E. Patient #14's physician, was interviewed on 6/07/10 at 4:25 PM. He stated he did not evaluate Patient #14 prior to placing him on an involuntary hold. He stated he social worker said the physician at the receiving hospital would not admit the patient unless he was placed on a hold. He stated he social worker said the physician at the receiving physician. Staff F, the Social Worker for Patient #14, was interviewed the medical record and confirmed she did not evaluate Patient #14's psychological status. She stated Patient #14's psychological status. She stated Patient #14's psychological status, She stated Patient #14's was placed on an involuntary hold for discharge planning purposes. She stated the hospital sometimes allowed patients on involuntary holds to be transported by family members. Staff G, the RN assigned to Patient #14 on 2/15/10, was interviewed on 6/08/10 at 2:40 PM. She stated Patient #14 seemed "normal and coherent" although he was sexually inappropriate with young males. She stated Patient #14 had wandred into a 21 year old male's room and said something inappropriate. She stated he was easily redirected by staff. She stated female staff were assigned to him and he was compliant and cooperative with them. She stated he just needed supervision. She stated his plan of care did not include any behavioral interventions. She said staff just reoriented him it needed it and he "was fine" in the room. Patient #14 was placed on an involuntary hold			AL CENTER		1	190 EAST BANNOCK STREET		
daughter will transport." Staff E, Patient #14's physician, was interviewed on 6/07/10 at 4:25 PM. He stated he did not evaluate Patient #14 prior to placing him on an involuntary hold. He stated Patient #14 was placed on a hold because the social worker said the physician at the receiving hospital would not admit the patient unless he was placed on a hold. He stated he did not speak with the receiving physician. Staff F, the Social Worker for Patient #14, was interviewed on 6/08/10 at 2:05 PM. She reviewed the medical record and confirmed she did not evaluate Patient #14's psychological status. She stated Patient #14's psychological status. She stated Patient #14 was placed on an involuntary hold for discharge planning purposes. She stated the hospital sometimes allowed patients on involuntary holds to be transported by family members. Staff G, the RN assigned to Patient #14 on 2/15/10, was interviewed on 6/08/10 at 2:40 PM. She stated Patient #14 seemed "normal and coherent" although he was sexually inappropriate with young males. She stated Patient #14 had wandered into a 21 year old male's room and said something inappropriate. She stated he was easily redirected by staff. She stated female staff were assigned to him and he was compliant and cooperative with them. She stated he just needed supervision. She stated he	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	
		Staff E, Patient #14 on 6/07/10 at 4:25 fevaluate Patient #1 involuntary hold. He placed on a hold be the physician at the admit the patient under the stated he did not physician. Staff F, the Social Vinterviewed on 6/08 the medical record evaluate Patient #14 vhold for discharge pathe hospital sometiminvoluntary holds to members. Staff G, the RN ass 2/15/10, was interviewed Patient #14 vhold for discharge pathe hospital sometiminvoluntary holds to members. Staff G, the RN ass 2/15/10, was interviewed Patient #16 coherent" although with young males. Wandered into a 21 something inappropeasily redirected by were assigned to his cooperative with the needed supervision did not include any lead to the said staff just reorie "was fine" in the roo	l's physician, was interviewed PM. He stated he did not 4 prior to placing him on an e stated Patient #14 was ecause the social worker said receiving hospital would not aless he was placed on a hold. It speak with the receiving hospital would not at speak with the receiving hospital would not at speak with the receiving hospital would not at 2:05 PM. She reviewed and confirmed she did not 4's psychological status. She was placed on an involuntary planning purposes. She stated mes allowed patients on be transported by family he was sexually inappropriate he was sexually inappropriate he was sexually inappropriate he was sexually inappropriate. She stated Patient #14 had year old male's room and said wriate. She stated he was staff. She stated he was staff. She stated he just he stated his plan of care behavioral interventions. She need on an involuntary hold	A				

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID;7EK211

Facility ID: ID1LGZ

If continuation sheet Page 23 of 53

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
NIO FUN	OF COMPLCTION	DENTIFICATION NO.	A, BUII	LDING	· · · · · · · · · · · · · · · · · · ·		
	_	130006	B. WIN	/G		06/10/2010	
	PROVIDER OR SUPPLIER (ES REGIONAL MEDIC	AL CENTER		19	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST BANNOCK STREET DISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
A 13	Continued From particle convenience of facilitate discharge. 482.13(d)(2) PATIE MEDICAL RECORD The patient has the contained in his or it reasonable time frat frustrate the legitime gain access to their must actively seek to quickly as its record. This STANDARD is Based on review of documentation of records and interview was determined the patient rights by releinformation for 2 of whose adoptive particle frustrated the legitime access to her adopt The findings included. The hospital documer record requests on adoptive parent for A computer-general showed an "A" next Patient #19's names request was still active as a still active and the patient #19's names request was still active as a s	ge 23 hospital staff in order to planning. NT RIGHTS: ACCESS TO oright to access information her clinical records within a me. The hospital must not atteefforts of individuals to own medical records and o meet these requests as keeping system permits. In not met as evidenced by: hospital policies and equests for release of medical was with staff and patients, it hospital failed to promote easing clinical record 2 patients (#18 and #19) ent requested records. This nate efforts of a parent to gain ed childrens' medical records. Ented receiving medical 3/27/09 and 2/18/10 from an Patient #18 and Patient #19, ed medical record form to Patient #18's name and s, indicating the record ive or the request had not	A 1	31		rty: of tiality rify rents vision tat ess to 1 be teir nt	
	parent of Patients' # one of the requests. stated she had mad of information in the which had been fulfi	tter, dated 2/01/10, from a 18 and #19, was attached to In the letter, the parent e 5 prior requests for release previous 4 years, none of lled. She further stated in the red "an irate phone call" from					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 24 of 53

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	130006	B, Wit	VG _		1	D/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDIC	AL CENTER		19	EET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET OISE, ID 83712		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
informing her that s requests because it the records any fast sending requests for A phone interview with 2:10 PM with the particular and particular and made multiple in records released and hospital's required professed and hospital and professed and hospital and professed and hospital and professed and professed and professed and hospital and hos	dical records department he did not have to send 5 is would not make them send ter and she should stop or records. I was conducted on 6/07/10 at trent who had requested her two adoptive children attent #19). She stated she requests to have medical and had completed the paperwork and provided proof ship to her children. She received the records or any on the hospital to her experiment. During one phone representatives from the apartment. During one phone atted she was told to stop or medical records, and during I she was told the childrens' and due to adoption and would be explained her children were medical care and she and the rant to repeat unnecessary any have previously been of stated that she had looked about release of records and I a right to access her information. I PM, an interview was Boise HIM Manager and the Administration. The Boise owledged two unfulfilled 7/09 and 2/18/10) for medical	A *	148	In response to A-148 co. Action Plan Implementation ✓ The adoptive mother of two minor adoptive chil in question was contacted telephone and all request medical records were set her attention by Federal Express, in accordance with the revised policy. Patient mother contacted by phonormal June 11, 2010. Records sent on June 14, 2010 at mother was contacted on 15, 2010 to confirm records. ✓ Health Information Management staff were educated on the policy clarification. Held on June 2010. QAPI Integration: ✓ Percent of Health Informal Management staff that he completed the required education on the revised policy by August 31, 20	the dren ed by ted nt to with ent's one on were nd the n June eipt of the nation have	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID; ID1LGZ

If continuation sheet Page 25 of 53

NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEPTISACES TAG SUMMARY STATEMENT OF DEPTISACES SUMMARY STATEMENT OF DEPTISACES SUMMARY STATEMENT OF DEPTISACES SUMMARY STATEMENT OF DEPTISACES THE DOISE, ID 383712 SUMMARY STATEMENT OF DEPTISACES SUMMARY STATEMENT OF DEPTISACES SUMMARY STATEMENT OF DEPTISACES THE DOISE, ID 383712 SUMMARY STATEMENT OF DEPTISACES SUMMARY STATEMENT O			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER ST LUKES REGIONAL MEDICAL CENTER (AND DEPRICIENCY MUST DE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) A 148 Continued From page 25 the documentation that the hospital had not followed-up with the parent and should have at the time. She also stated the first request had been shredded but should not have been shredded but should not have been shredded but should not have been shredded with the parent and should have sent a response to the parent. The hospital's policy, Confidentiality and Security of Patient Information in Health Information Management (HIM), dated 1/25/10, stated that in order to protect all partiest identifies, records on adopted infants would be released only by court order once the child had been discharged from the hospital and identifying information of birth parents) would be deleted unless the court specified otherwise. The Boise HIM Manager was interviewed on 6/07/10 at 2:35 PM. Her remarks were consistent with the above-referenced policy. She explained the hospital released information on adoptive onlider to the adoptive agency or an adoptive parent only by court order. When released, the information regarding the birth parents was "blacked out" to protect the privacy of the birth parents. When seked how the policy or protectic was established, she explained it was based on information from the ledtho Hospital Association. The Health Information Manager provided the reference from the Idaho Hospital Association upon surveyor request. The Guidebook Issues in Health Care Management, published in 2008 by the Idaho Hospital Association had a section titled Release	, , , , , , , , , , , , , , , , , , , ,		42000		G		
ST LUKES REGIONAL MEDICAL CENTER 190 EAST BANNOCK STREET BOISE, ID 83712	MAME OF P	POVIDER OR SUPPLIER	13000	ETE	PECY ADDRESS CITY STATE ZID CODE	06/10	J/2010
A 148 Continued From page 25 the documentation that the hospital had not followed-up with the parent and should have at the time. She also stated the first request had been shredded. Although the hospital would not have released the medical record information to the requestor based on the hospital's policy (referenced below), their department should have sent a response to the parent. The hospital's policy, Confidentiality and Security of Patient Information in Health Information Management (HIM), dated 1/25/10, stated that in order to protect all parties identities, records on adopted infants would be released only by court order once the child had been discharged from the hospital would be deleted unless the court specified otherwise. The Boise HIM Manager was interviewed on 6/07/10 at 2:35 PM. Her remarks were consistent with the above-referenced policy. She explained the hospital released information on adoptive children to the adoptive agency or an adoptive parent only by court order. When released, the information regarding the birth parents was "blacked out" to protect the privacy of the birth parents. When asked how the policy or practice was established, she explained it was based on information from the Idaho Hospital Association. The Health Information Manager provided the reference from the Idaho Hospital Association upon surveyor request. The Guidebook Issues in Health Care Management, published in 2008 by the Idaho Hospital Association had a section titled Release			AL CENTER	1	90 EAST BANNOCK STREET		
the documentation that the hospital had not followed-up with the parent and should have at the time. She also stated the first request had been shredded but should not have been shredded. Although the hospital would not have released the medical record information to the requestor based on the hospital's policy (referenced below), their department should have sent a response to the parent. The hospital's policy, Confidentiality and Security of Patient Information in Health Information Management (HIM), dated 1/25/10, stated that in order to protect all parties' identities, records on adopted infants would be released only by court order once the child had been discharged from the hospital and identifying information (of birth parents) would be deleted unless the court specified otherwise. The Boise HIM Manager was interviewed on 6/07/10 at 2:35 PM. Her remarks were consistent with the above-referenced policy. She explained the hospital released Information on adoptive children to the adoptive agency or an adoptive parent only by court order. When released, the information regarding the birth parents was "blacked out" to protect the privacy of the birth parents. When asked how the policy or practice was established, she explained it was based on information from the Idaho Hospital Association. The Health Information Manager provided the reference from the Idaho Hospital Association upon surveyor request. The Guidebook Issues in Health Care Management, published in 2008 by the Idaho Hospital Association at a section titled Felesse	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
	A 148	the documentation followed-up with the time. She also been shredded but shredded. Although released the medic requestor based on (referenced below), sent a response to The hospital's polic of Patient Information Management (HIM) order to protect all padopted infants woo order once the child the hospital and ideparents) would be a specified otherwise. The Boise HIM Mar 6/07/10 at 2:35 PM. with the above-refe the hospital release children to the adopparent only by cour information regarding "blacked out" to proparents. When ask was established, shinformation from the Health Informareference from the upon surveyor required. The Guidebook Issu Management, public Hospital Association	that the hospital had not a parent and should have at stated the first request had should not have been the hospital would not have all record information to the the hospital's policy their department should have the parent. You Confidentiality and Security on in Health Information to the parent. You Confidentiality and Security on in Health Information to the parent of the p	A 148			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

001		Ħ	30/	02
	PHIMIED:	UUY	とはんし	•
	FORM	APP	ROVE	ΞD
	OMB NO.	093	8-03	91

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1		130006	B. WII			0 <u>6/10</u>)/2010
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
STLUKE	S REGIONAL MEDIO	AL CENTER		1	BD EAST BANNOCK STREET COISE, ID 83712		
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 148	stipulate that the adinspect the adopted with state statues of inspection should restricted, or identificate, or identificate of the birth parents. During an interview surveyors asked the hospital's policy regrecords to adoptive reference provided Care Management stated she realized be necessary to reseek legal council of withholding medicate parents. The hospital failed adoptive parents in information on their 482.13(e) USE OF Patient Rights: Respatients have the rimental abuse, and patients have the riseclusion, of any forcercion, discipline staff. Restraint or to ensure the immediation, a staff mendiscontinued at the	deach institution's policy dopting parents had the right to be's medical records, consistent on minority. However, such not include the sealed birth fying information on the child's s, it was necessary for the neasures to mask the identity. If on 6/08/10 at 12:40 PM, he Boise HIM Manager how the garding not releasing medical exparents was derived from the (Guidebook Issues in Health). The Boise HIM Manager there was "a gap" and it would wisit the policy and perhaps on the appropriateness of all records from adoptive to protect and promote ghts to access medical		148	In response to A-15 Action Plan Responsible P Bev Holland, MSN, RN, N Administration St. Luke's Children's Hospital and Judones, MSN, RN, NEA-BO Administrator Women's Se Process Improvements: Draft of revised restrain policy, order sets, check and audit process. Draft completed on June 29, 2 Approval of revised Respolicy and order sets, checklist and audit process by August 31, 2010. The medical record for patients on restraints will reviewed by the Nursing Administrative Supervise Charge Nurse. Initiated August 31, 2010. Action Plan Implementation: Management Council upor regarding Restraint orderiand use. Held on June 17 2010.	arty: (E-BC, dy c, crvices t clist, t colo. ctraint ess.	
		Observation Supervisor 10:75V04		F	-((b) (D) (D4) (77) If east		Dees 27 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130006	B, WING _	MACON TO PARTY.	06/10	; 1/2010
	ROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET 30ISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
A 154	Based on staff inter records, it was dete ensure 2 of 2 patier whom chemical and used, were free from imposed as a mear patients' rights bein include: 1. Patient #16 was admitted to the hosself-reported overdedocumented that shad a 1:1 sitter. Panursing note, dated stated Patient #16 is staff attempted to rethe note document give the cell phone the patient that if shup the cell phone, serestraints. The documentation interview by the hos Accreditation and Nat 2:00 PM. Patient #16 was the restraints. 2. Patient #38 was atto the hospital on 4/polydrug ingestion. contained a nursing AM, which stated Pand her oxygen satifurther documented in the patient was the polydrug ingestion.	view and review of medical rmined the hospital failed to hts (#16 and #38) reviewed, for diversity of the threat of restraints were in the threat of restraints is of coercion. This resulted in giviolated. The findings a 20-year-old female, pital on 4/23/10, after a ose. Patient #16's record he was on a suicide watch and tient #16's record contained a 4/26/10 at 12:16 PM, which had a cell phone which the emove from her possession. The edit of the staff so staff instructed he did not cooperate and give he would be placed in was confirmed during an	A 154	In response to A-154 conseducation regarding restruse. Held on June 22, 20 Nursing Practice Council Nursing Education Council Council Regarding restruse. Held on July 6, 201 Administrative Supervise update regarding restrain Held on July 7, 2010. Management Council communication regarding expectation that restraint never to be used as a form coercion or punishment. July 8, 2010. OAPI Integration: Implementation of an autool and reporting process the following metric: 1) Percent of direct-care Rice (excluding staff that are leave) that have reviewed revised policy as indicated a signed acknowledgement This reporting process we end as of August 31, 201	mittee raint 010. 1 and neil raint 0. or nt use. g the ss are m of Sent dit ss for N staff on d the ed by ent. rill	

38/ 62

PRINTED: 06/29/2010

_		AND HUMAN SERVICES & MEDICAID SERVICES				NPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILC	LTIPLE CONSTRUCTION DING	(X3) DATE SUI COMPLET	RVEY
		130006	B. WING		06/10	/2010
	ROVIDER OR SUPPLIER S REGIONAL MEDIC	AL CENTER	ş	STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(XS) COMPLETION DATE
A 166	explained the physis spoke with Patlent is physician said to Patcholce but to get the would restrain her if the documentation interview by the host Accreditation and Nat 1:40 PM. The hospital falled the from the threat of recoercion. 482.13(e)(4)(i) PATOR SECLUSION The use of restraint (i) in accordance with patlent's plan of car. This STANDARD is Based on staff interrecords and hospital failed to incorporated restraint (incorporated restraint for 2 of 2 patients (if were chemically and This had the potenticoordination of paties staff in lesser intervipatients. The finding The Hospital's policion 12/14/09, stated in accordance with the spoke	It I've done it." The note cian came into the room and #38. The note stated the attent #38 that "she had no eated" and told her that they if need be. was confirmed during an epital's Director of lursing Operations on 6/09/10 to ensure Patient #38 was free estraints as a means of IENT RIGHTS: RESTRAINT or seclusion must be—th a written modification to the let. Is not met as evidenced by: view and review of medical to policies, it was determined to ensure hospital staff int usage into the plans of care #16 and #38) reviewed, who di/or physically restrained. It is interfere with eat care and could not direct entions before restraining	A 16	Action Plan Responsible Pa Bev Holland, MSN, RN, NE Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Ser Process Improvements: Draft of revised restraint policy, order sets, checkly and audit process.	rty: 3-BC, y vices ist, 010. raint ss. be r or	

FORM CM5-2567(02-99) Previous Versions Obsolute

followed. Examples include:

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 29 of 5

PRINTED: 06/29/2010 FORM APPROVED OMB_NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A, BUILDIN		С	
		130006	B. WING		06/10/2010	
	ROVIDER OR SUPPLIER S REGIONAL MEDIC	AL CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET IOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
A 166	1. Patient #38 was to the hospital on 4/ polydrug ingestion. dictated by the phys stated that Patient # half bottle of Extra 6 of caffeine pills, and History and Physica remained quite aler the ED. The ED His Patient #38's blood 10. This was a nor and Physical docum was to repeat Paties "monitored contin monitoring because ingestion by self repor alterations in met Benadryl ingestion." Patient #38 was dis PM. The physician at 1:07 PM, stated F (increased heart rat pressure), change in Tylenol blood levels actually occurred." The hospital's restra of 2010 identified Patient #38's record dated 5/01/10 at 12:	a 13-year-old female admitted /30/10 after a self-reported The ED History and Physical scician on 4/30/10 at 10:58 PM, #38 reported she had taken a Strength Tylenol, 2 full boxes of Benadryl. The all stated that Patient #38 t without obvious symptoms in story and Physical stated Tylenol levels were less than mal result. The ED History nented the plan of treatment in #38's Tylenol levels, and uously with cardiorespiratory of her substantial caffeine port and also for hallucinations intal status as a result of her charged on 5/01/10 at 2:35 is progress, note dated 5/01/10 Patient #38 had no tachycardia e), hypertension (high blood in mental status, or increased in "to suggest claimed ingestion aint log for the calender year attent #38 as being restrained. If contained a nursing note, e40 AM, that stated Patient	A 166	In response to A-166 comparing the process of the following metrics: 1) Percent of direct-care RN (excluding staff that are on leave of that are on leave) that have reviewed.	mittee t use. and cil aint 0. or t use. ss olds, vior, other 1, tt for staff n the	
	saturation monitor o documented that Pa to die, God told me	ine out and her oxygen iff. The note further atient #38 stated, "It's my time it's my time. I had one thing to "The note explained that the		revised policy as indicated a signed acknowledgemen	t.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 30 of 53

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130006	B. WI			I	0/2010
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	00/10	<i>J</i> /2010
ST LUKE	S REGIONAL MEDIC	AL CENTER		19	90 EAST BANNOCK STREET OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 166	Continued From particular physician had come Patient #38. The not Patient #38 that "she treated" and told he need be. Patient #38's record and Doctor's Orders 5/01/10 at 1:00 AM. the Restraint form to JUSTIFICATION FOR Patient #38 was pulwas expressing suic "sedate/restrain PR" "Demonstrates attered ther life saving dev "Violent/self-destruction on the Doctor's Ordunder the "Nonviole beside "Initiate/Rend checked. On the Redirectly above the platted "I have example the above restraint of Restraint form, at 1:00 AM. minutes after signing Restraint form, at 1:00 and amnesia during hour as needed for corder was written and the Doctor's Orders and Progress Notes	ge 30 Into the room and spoke with one stated the physician said to e had no choice but to get in that they would restrain her if it contained a Progress Notes is RESTRAINTS form, dated in the progress notes side of itled CLINICAL DR RESTRAINTS stated ling at her IV line again and cidal desire and will in the sections of itled can be in the progress notes side of itled CLINICAL DR RESTRAINTS stated ling at her IV line again and cidal desire and will in the sections of itled can be in the sections of itled can be in the section of itled can be in the section of itled can be in the patient and certify order is indicated, in the patient and certify order is indicated, in the physician on On the same date, 5 go the Doctor's Orders side of induce sleepiness surgery) 4-6 mg IV every 1 excessive agitation. This id signed by the physician in column of a Doctor's Orders form.		166		ith	
	is a preoperative sec conscious sedation.	rug Handbook states Versed dative and a medication for The medication was listed ess and amnesia. Versed			libration (Dui CZ) If continu		2000 21 of 52

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FONIT	or Connection	DENTIFICATION NOMBER.	A. BUIL	LDING			
		130006	B, WIN	IG	06/1	0/2010	
	ROVIDER OR SUPPLIER ES REGIONAL MEDIÇ	AL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712			
(X4) ID PAEFIX TAG	(EACH DÉFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ECTION HOULD BE PROPRIATE	(X5) COMPLETION DATE		
A 166	was listed as to be surgeries to induce listed dosing recom 12 to 16 was to initi IV. The 2010 Nursi Versed dosing may of up to 10 mg to resedation. Patient #38's MAR 4 mg of Versed on and 6:28 AM, for a 15 hours and 6 minu not document the regiven at 3:00 AM ar Patient #38's POC to chemical restraint of interventions to the medication administ The hospital's Direct Nursing Operations starting at 1:40 PM, #38's record. She shot updated becaus chemically restrain the POC did not have to the Hospital staff failed into Patient #38's pl. 2. Patient #16 was to the hospital on 4/drug ingestion. Patient was on a suicid	given before and/or during general anesthesia. The mendations for children ages ally give no more than 2.5 mg ing Drug Handbook states that be increased to a total dose ach the desired level of documented she had received 5/01/10 at 1:22 AM, 3:00 AM, total of 12 mg over a period of tes. The medical record dideason the medication was and 6:28 AM. Was not modified to reflect the orders or the behaviors and behaviors to include tration. It of Accreditation and was interviewed on 6/09/10 She had reviewed Patient stated Patient #38's POC was be the hospital staff did not the patient and, therefore, the obe updated. It o incorporate restraint usage an of care. It a 20-year-old female admitted 23/10, after a self-reported ent #16's record documented e watch and had a 1:1 sitter.	A 1	DEFICIENCY)			
		order dated 4/23/10 at 10:10 sing staff to administer hard					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: (D1LGZ

If continuation sheet Page 32 of 53

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER 130006 B. WING O6/10/2010 STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER 190 EAST BANNOCK STREET 190			40000					
ST LUKES REGIONAL MEDICAL CENTER (XA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 166 Continued From page 32 restraints on all four extremities. Hard restraints refer to leather material with belts to secure the patient's extremities to the bed. The physician documented on the Emergency Department section of the medical record, at 10:39 PM on 4/23/10. Under the heading History of Present Illness, was entered, "very belligerent and fighting treatment and she was placed in soft restraints after which she became	NAME OF E	PAUSED OR FURBUIED	130006		Ι		06/1	0/2010
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 166 Continued From page 32 restraints on all four extremities. Hard restraints refer to leather material with belts to secure the patient's extremities to the bed. The physician documented on the Emergency Department section of the medical record, at 10:39 PM on 4/23/10. Under the heading History of Present Illness, was entered, "very belligerent and fighting treatment and she was placed in soft restraints after which she became			AL CENTER			190 EAST BANNOCK STREET		
restraints on all four extremities. Hard restraints refer to leather material with belts to secure the patient's extremities to the bed. The physician documented on the Emergency Department section of the medical record, at 10:39 PM on 4/23/10. Under the heading History of Present Illness, was entered, "very belligerent and fighting treatment and she was placed in soft restraints after which she became	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR			(X5) COMPLETION DATE
Soft restraints were devices made of soft material that are designed to safely fit around the wrists, ankles, or chest of a patient to prevent patients from harming themselves. Patient #16's record contained a nursing note, dated 4/25/10 at 6:22 PM, which stated Patient #16 was agitated and yelling. The note indicated she removed her telemetry unit and threw it. Documented within the hospital's interdisciplinary Care Management Plan, dated 4/25 and 4/26 was, "Soft restraints prn, 1 wrist and 1 ankle" There was no documentation in Patient #16's Interdisciplinary Care Management Plan, to include alternative or less restrictive measures to be attempted before applying soft or hard restraints prn. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM and she reviewed Patient #16's Interdisciplinary Care Management Plan did not include alternative or less restrictive measures to be attempted before resorting to restraints.		restraints on all four refer to leather mate patient's extremities. The physician docu Department section 10:39 PM on 4/23/1 of Present Illness, who belligerent and fight placed in soft restrasomnolent." Soft restraints were that are designed to ankles, or chest of a from harming thems. Patient #16's record dated 4/25/10 at 6:2 #16 was agitated an she removed her tel Documented within Care Management I was, "Soft restraints. There was no docur Interdisciplinary Carinclude alternative obe attempted before restraints prn. The hospital's Direct Nursing Operations starting at 1:40 PM at #16's record. She conclude alternative of the patient of the control of the patient of th	r extremities. Hard restraints erial with belts to secure the sto the bed. mented on the Emergency of the medical record, at 0. Under the heading History was entered, "very ting treatment and she was aints after which she became devices made of soft material stafely fit around the wrists, a patient to prevent patients selves. It contained a nursing note, 22 PM, which stated Patient of yelling. The note indicated demetry unit and threw it, the hospital's interdisciplinary Plan, dated 4/25 and 4/26 prn, 1 wrist and 1 ankle" mentation in Patient #16's re Management Plan, to or less restrictive measures to applying soft or hard tor of Accreditation and was interviewed on 6/09/10 and she reviewed Patient #16's re Management Plan did not or less restrictive measures to reless restrictive measures to reless restrictive measures to reless restrictive measures to	A -	166			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7ÉK211

Facility ID: ID1LGZ

If continuation sheet Page 33 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		130006	B, Wi	VG		06/10)/2010
	ROVIDER OR SUPPLIER	AL CENTER		1:	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREP TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
A 169	measures into Patil 482.13(e)(6) PATIE OR SECLUSION Orders for the use never be written as needed basis (PRN This STANDARD is Based on staff interrecords, hospital producers were not wripatients (#16 and #physical restraints to potential to result in unnecessarily and the findings included in Patient #38 was to the hospital on 4 polydrug ingestion. documented she was a 1:1 sitter. The Eto by the physician on that Patient #38 repottle of Extra Strencaffeine pills, and 2 ED History and Phyremained quite aler the ED. The ED History and Phyremained quite aler the ED. The ED History and that Patient #38 reput the ED. The ED History and Phyremained quite aler the ED. The ED History and the ED History and cardiorespiratory more result. The ED History and cardiorespiratory more results and cardiorespiratory more results.	to incorporated less restrictive ent #16's plans of care. ENT RIGHTS: RESTRAINT of restraint or seclusion must a standing order or on an as i). is not met as evidenced by: rview, review of medical olicies and restraint log, it was ipital failed to ensure restraint itten as PRN orders for 2 of 2 is if or whom chemical and/or were used. This had the a patients being restrained compromise patient safety. a 13-year-old female admitted /30/10 after a self-reported Patient #38 's record as on a suicide watch and had 0 History and Physical dictated 4/30/10 at 10:58 PM, stated corted she had taken a half angth Tylenol, 2 full boxes of itill boxes of Benadryl. The visical stated that Patient #38 t without obvious symptoms in		166	In response to A-169 Action Plan Responsible Pa Bev Holland, MSN, RN, NI Administration St. Luke's Children's Hospital and Jud Jones, MSN, RN, NEA-BC, Administrator Women's Ser Process Improvements: Draft of revised restraint policy, order sets, checkl and audit process. Draft completed on June 29, 20 Approval of revised Rest policy and order sets, checklist and audit proce August 31, 2010. The medical record for patients on restraints will reviewed by the Nursing Administrative Supervise Charge Nurse. Initiated I August 31, 2010. Action Plan Implementation: Management Council upo regarding Restraint order and use. Held on June 17 2010.	rty: 3-BC, y vices list, 010. traint ss by be or or by	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

;2083812861

PRINTED: 06/29/2010 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMMUTIFIE CONSTRUCTION COMMUTIFIE COMMUTIFIE CONSTRUCTION COMMUTIFIE COMMUTI	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	<u>0938-0391 </u>
NAME OF PROVIDER OR SUPPLER ST LUKES REGIONAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIF CODE 190 EAST BANNOOK STREET BOISE, ID 83712 DISC, ID 83712 A 169 Continued From page 34 also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels 'to suggest claimed ingestion actually occurred." The hospital's restraint log for the calender year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 1:04 AM, which stated Patient #38 wanted her IV out and her saturation monitor off. The note further occumented that Patient #38 stated, "It my time to die. God told me it's my time 1 had one thing to do, and I've done it." The note explained the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated \$/01/10 at 1:04 AM. The progress note side of the Restraint stated Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated \$/01/10 at 1:04 AM. The progress note side of the Restraint form dated \$/01/10 at 1:04 AM. The progress note side of the Restraint stated Patient #38 was pulling at her IV again and was expressing suicidal desire and will "sedate/heart at the progress note side of the Restraint form dated "Demonstrates attempts to remove airway or other ife saving devices" and "Violent/self-destructive behavior" were checked.	STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/GUPPLIÉF/CLIA IDENTIFICATION NUMBER:	1 .			(X3) DATE SU COMPLET	RVEY ED
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE A 169 CONTINUED From page 34 also for hallucinations or alterations in mental status as a result of her Benadryl ingestion. Patient #38 was discharged on 5/01/10 at 2:35 P.M. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels' to suggest claimed ingestion actually occurred.'' The hospital's restraint log for the calender year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV out and her saturation monitor off. The note explained the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated 5/01/10 at 1:00. Am The progress note side of the Restraint form title Clinical Justification for Restraints stated Patient #38 was pulling at her IV again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Violen/Self-Gestructive behavior" were checked.				1			\ c	;
ST LUKES REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (PAGE DEFICIENCY MUST BE PRECEDED BY FULL TAGE DEFICIENCY MUST BE PRECEDED BY FULL TAGE DEFICIENCY MUST BE PRECEDED BY FULL TAGE DEFICIENCY MUST BE PROVIDED BY FULL TAGE DEFICIENCY MUST BE PROVIDED BY FULL TAGE DEFICIENCY MUST BE PROVIDED BY FULL TAGE DEFICIENCY ACTION SOULD BE COMPUTED BEFORE AND OF CORPECTION CONTENTS TO MUST BE PROVIDED BY FULL TAGE DEFICIENCY ACTION SOULD BE CAME TO MUST BE PROVIDED BY FULL TAGE DEFICIENCY ACTION SOULD BE CAME TO MUST BE PROVIDED BY FULL TAGE DEFICIENCY ACTION SOULD BE CAME TO MUST BE PROVIDED BY FULL TAGE DEFICIENCY ACTION SOULD BE CAME TO MUST BE PROVIDED BY FULL TAGE OF TAGE			130006	B. WI	νĢ		06/10	/2010
ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 PROVIDERS PLAN OF CORRECTION (PREDIX TAGE TAGE TAGE PROVIDERS PLAN OF CORRECTION (PROBLEM PROPERLY TAGE PROVIDERS PLAN OF CORRECTIVE ACTION (PROBLEM PROPERLY TAGE PROVIDERS PLAN OF CORRECTIVE ACTION (PROBLEM PROPERLY TAGE PROVIDERS PLAN OF COMBET PROPERLY TAGE PROVIDERS PLAN OF COMBET PROPERLY TAGE PROVIDERS PLAN OF CACH COMBET PROPERLY TAGE PROVIDERS PLAN OF CACH COMBET. TAGE PROVIDERS PLAN OF CACH COMBET. TAGE PROVIDERS PLAN OF CACH COMBET. TAGE PROVIDERS PLAN OF CACH CACH CACH CACH CACH CACH CACH CAC	NAME OF P	ROVIDER OR SUPPLIER						
A 169 Continued From page 34 also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the calender year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV out and her saturation monitor off. The note further documented that Patient #38 wanted her IV out and belle. God told me it's my time. I had one thing to do, and I've done it." The note explained the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note fact the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "ne had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated 5/01/10 at 1:00 AM. The progress note side of the Restraints stated Patient #38 was pulling at her IV again and was expressing suicidal desire and will "sedstar/estrain the resection of "Demonstrates	ST LUKE	S REGIONAL MEDIC	AL CENTER					
also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the calender year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained the physician came into the room and spoke with Patient #38. The note. stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated \$/01/10 at 1:00 AM. The progress note side of the Restraint form title Clinical Justification for Restraints stated Patient #38 was pulling at her I'v again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Vicient/self-destructive behavior" were checked.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	ΙX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(XS) COMPLETION DATE
was checked to Initiate/Renew restraint use. This form was signed by the obysician on 5/01/10 at	A 169	also for hallucination status as a result of Patient #38 was dis PM. The physician at 1:07 PM, stated (increased heart rain pressure), change if Tylenol blood levels actually occurred." The hospital's restrof 2010 identified Phatient #38's record dated 5/01/10 at 12 #38 wanted her IV off. The note further #38 stated, "It's my my time. I had one The note explained room and spoke with stated the physician had no choice but to they would restrain Patient #38's record and Doctor's Order 5/01/10 at 1:00 AM the Restraints stated Plagain and was explained room strates atted the rife saving de "Violent/self-destruction of the Doctor's Order Tylenonstrates atted the physician and was explained in the physician and was explained the rife saving de "Violent/self-destruction of the Doctor's Order Tylenonstrates atted the Tylenonstrates	ins or alterations in mental finer Benadryl ingestion." Icharged on 5/01/10 at 2:35 is progress note dated 5/01/10 Patient #38 had no tachycardiate), hypertension (high blood in mental status, or increased in to suggest claimed ingestion and to suggest claimed ingestion at the suggest ingestion in the suggest ingestion in the suggest ingestion at the suggestion at the suggestion in the suggestion in suggestion in the suggestion in	A	169	Medical Executive Cone education regarding resuse. Held on June 22, 2 Nursing Practice Counce Nursing Education Counceducation regarding resuse. Held on July 6, 20 Administrative Supervise education regarding restuse. Held on July 7, 20 Management Council communication regarding expectation that restrain never to be ordered PRN Sent July 8, 2010. OAPI Integration: Implementation of an autool and reporting process the following metrics: 1) Percent of direct-care RN (excluding staff that are decouncied policy as indicated a signed acknowledgeme 2) Percent compliance of required restraint documentation. This reporting process will end	nmittee traint 2010. vil and ncil traint 10. sor raint 10. ss for dit ss for V staff on ed by nt.	

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130006	B. WIN	1G		06/10)/2010
NAME OF PROVIDER OR SUI ST LUKES REGIONAL		AL CENTER		18	EET ADDRESS, CITY, STATE, ZIP CODE 80 EAST BANNOCK STREET OISE, ID 83712		
PREFIX (EACH DEF	CIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Versed (a mand amnesia hour as need to am and amnesia hour as need to reviewed Par was unclear ordered as a the patient's dosing order every hour, at the hospital' 12/09, did not as unaccepta Accreditation interviewed of stated restrait. The hospital not written as 2. Patient #1 admitted on overdose. Two pre-primand timed, where the first Progrestraints for documented consistently fiviolent and/or in addition, the strain of the str	1:05 A edicating during led for sident was east and Non 6/0s on 6/0s o	MM, the physician ordered on used to induce sleepiness g surgery) 4-6 mg IV every 1 excessive agitation. of Medical Affairs was 3/10 starting at 1:15 PM. He 38's record. He stated that it as to whether the Versed was local restraint or used to treat y. He stated the physician's excessive in that it was ordered ded. y titled Restraints, revised lifty PRN orders for restraints the hospital's Director of lursing Services was 1/10 starting at 2:00 PM. She are not to be ordered as PRN.	A 1	169			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 36 of 53

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		130006	B. WIN	۱G			0/2010
	ROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER	•	19	EET ADDRESS, CITY, STATE, ZIP CODE 30 EAST BANNOCK STREET OISE, ID 83712		
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	TÉMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID FREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
A 169	AMA, and is not me On the Doctor's Ord documented the pa Both the soft restrai ankle boxes were of documentation in P showed restraints w The second form, of documented Patien consistently follow/o violent and/or had s The Doctor's Orders Patient #16' s restra the order expired in handwritten docume side. The soft restraints, and both ankles box There was no nursin restraints were used In an interview cond 1:40 PM, the hospits and Nursing Service were not used 4/25/ were not to be order	dically cleared to leave safely. ders side of the form, tient had Nonviolent Behavior. Ints and the one wrist and one hecked. There was no atient #16's record that were used that day. ated 4/26/10 at 12:00PM, t #16 was unable to understand directions and was elf-destructive behavior. Is side of the form documented aint order was renewed and 4 hours. There was no entation on the Progress Note thard restraints, both wrists were all checked off. Ing documentation that showed that day. Ilucted on 6/09/10 starting at al's Director of Accreditation es confirmed that restraints 10 and 4/26/10 and restraints red as prn.	Α-	169			
A 178	not written as prn or	o ensure restraint orders were ders. ENT RIGHTS: RESTRAINT	A 1	178			
	management of viol	eclusion is used for the ent or self-destructive dizes the immediate physical					

PRINTED: 06/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	RVEY TED
		130006	B. WING		06/10)/2010
	OVIDER OR SUPPLIER	AL CENTER	s	STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	JULD BE	(X5) COMPLETION DATE
still F was Temeobattipti Tieir Ptipdabpop	the patient must be inhour after the inition of by arrown and the patient must be inhour after the inition of a patient must be a part of a patient must be patient must be a part of a patient must be patient must be patient of a patient must be patient of a patient must be patient of the patient must be patient must be patient must be patient of the patient of the patient must be patie	ge 37 It, a staff member, or others, seen face-to-face within ation of the intervention If other licensed Independent murse or physician assistant and in accordance with the field in paragraph (f) of this sent met as evidenced by: view and review of medical all policy, the hospital failed to at (#38) reviewed who was ad for violent/self destructive a face-to-face evaluation by an ed person within 1-hour after intervention. This resulted in ospital to adequately assess of behaviors and es. The findings include: If would do an in-person ents within 1 hour after the aint. This policy was not 3-year-old female admitted to /10 after a self-reported patient #38's record as on a suicide watch and had belistory and Physical dictated 30/10 at 10:58 PM, stated as the had taken a half bottle vienol, 2 full boxes of caffeine s of Benadryl. The ED I stated that Patient #38	A 17	Action Plan Responsible Par Bev Holland, MSN, RN, NF Administration St. Luke's Children's Hospital and Jud Jones, MSN, RN, NEA-BC, Administrator Women's Ser Process Improvements: Draft of revised restraint policy, order sets, check and audit process. Draft completed on June 29, 2 Approval of revised Respolicy and order sets, checklist and audit process by August 31, 2010. The medical record for patients on restraints will reviewed by the Nursing Administrative Supervise Charge Nurse. Initiated August 31, 2010. Action Plan Implementation Management Council up regarding Restraint order and use. Held on June 17 2010.	rty: 3-BC, y vices list, 010. traint ess.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 38 of 53

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		, 130006	B. WING		06/10)/2010
.,	ROVIDER OR SUPPLIER ES REGIONAL MEDIC	al Center	19	EET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE
A 178	remained quite aler the ED. The ED Histocumented that Palevels were less that result. The ED Histocument with the ED Histocume	t without obvious symptoms in	A 178	In response to A-178 conseducation regarding restruse. Held on June 22, 20. Nursing Practice Council Nursing Education Counceducation regarding restruse. Held on July 6, 201. Administrative Supervise education regarding restruse. Held on July 7, 201. OAPI Integration: Implementation of an autool and weekly reporting process for the following metrics: 1) Percent of directed RN staff (excluding that are on leave) that has reviewed the revised politicated by a signed acknowledgement. 2) Percenting process will enof August 31, 2010.	mittee raint 010. I and cil raint 0. or raint 0. dit g rect- staff ve icy as ercent I This	

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	DING	NSTRUCTION	(X3) DATE SU	TEO
	130006	B. WIN	G		06/10)/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICA	AL CENTER		190 EAS	ODRESS, CITY, STATE, ZIP CODE T BANNOCK STREET ID 83712		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	(D PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
Restraints, stated Pa IV line again and wa and will "sedate/rest "Demonstrates atten other life saving dev "Violent/self-destruct The Doctor's Orders was checked to Initia form was signed by 1:00 AM. At 1:05 AM Versed (a medication and amnesia during hour as needed for e The 2010 Nursing D was a preoperative s conscious sedation. as to induce sleeping was listed as to be g surgeries to induce g listed dosing recomn 12 to 16 was to initia IV. The 2010 Nursin Versed dosing could of up to 10 mg to rea sedation. Patient #38's MAR d additional doses of V and at 6:28 AM. The Patient #38's medica evaluation by an LIP hour of the administr restraints. The hospital's Direct Nursing Operations v	tle Clinical Justification for atient #38 was pulling at her is expressing suicidal desire rain PRN." The section of inpts to remove airway or lices" and tive behavior" were checked. It is side of the Restraint form ate/Renew restraint use. This the physician on 5/01/10 at M, the physician ordered in used to induce sleepiness surgery) 4-6 mg IV every 1	Α-	78			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

50/ 62

FORM APPROVED

CENTERS FOR	MEDICARE	8 MEDICAID SERVICES				OMB NO.	<u> 0938-0391</u>
STATEMENT OF DEFIC AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		130006	B. WI	VG) ()/2010
NAME OF PROVIDER O	OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ST LUKES REGIO	NAL MEDIC	AL CENTER		15	90 EAST BANNOCK STREET OISE, ID 83712		
PREFIX (EAC	CH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 178 Continu	ed From pa	ige 40	Α.	178			, <u>.</u> <u> </u>
#38's re reasses within a medical The hos chemical evaluati within 1 482.13(RESTR [there medical Alternat attempts This ST Based of with state ensure leastempts chemical of alternatempts resulted use of reinclude: 1. Paties to the hopolydrug docume ED Histophysicial Patient statempts of alternatempts of altern	sment of P n hour of the flon. spital failed ally restrain- on by an ap -hour after in e)(16)(iii) P. AINT OR S nust be docured of ives or other ed (as appliant of the ed (as appliant of the ed (as appliant of the fl, it was de less restricted before the (#16 and # ally and/or partices and/ ed before a in the Inab estraints where the the grant on 4. grant on 4.	indicated a face-to-face atient #38 was not completed e adminstration of the to Patient #38, who was ed, received a face-to-face opropriately qualified person the initiation of the intervention. ATIENT RIGHTS: ECLUSION umentation in the patient's er less restrictive interventions		178	In response to A-18 Action Plan Responsible P. Bev Holland, MSN, RN, N Administration St. Luke's Children's Hospital and Jude Jones, MSN, RN, NEA-BC Administrator Women's Se Process Improvements: Draft of revised restrain policy, order sets, check and audit process. Draft completed on June 29, 2 Approval of revised Respolicy and order sets, checklist and audit proces by August 31, 2010. The medical record for patients on restraints will reviewed by the Nursing Administrative Supervise Charge Nurse. Initiated Management Council upder regarding Restraint orderiand use. Held on June 17 2010.	arty: E-BC, iy , arvices t ilist, t 010. traint ess.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 41 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	William III
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
							,
		130006	B, WI	1G		06/10	/2010
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S REGIONAL MEDIC	AL,CENTER		В	OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO! CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 186	pills, and 2 full boxed History and Physical remained quite aler the ED. The ED History and Physical were less than 10. ED History and Physical reatment was to relevels, and "monlificational caffeine also for hallucination status as a result of Patient #38 was dis PM. The physician at 1:07 PM, stated I (increased heart rational pressure), change in Tylenol blood levels actually occurred." The hospital's restrated 10 identified Physician 4:00 identified Physician was a result of 2010 identified Physician came into the documented that Patient #38 wanted her IV I saturation monitor of documented that Patient #38. The nero Patient #38. The nero Patient #38. The nero Patient #38 that "she her and present #38 that "she	es of Benadryl, The ED al stated that Patient #38 t without obvious symptoms in		186	In response to A-186 come education regarding restruse. Held on June 22, 20. Nursing Practice Council Nursing Education Counceducation regarding restruse. Held on July 6, 201. Administrative Supervise education regarding restruse. Held on July 7, 201. OAPI Integration: Implementation of an autool and reporting process the following metrics: 1) Percent of direct-care RN (excluding staff that are cleave) that have reviewed revised policy as indicated a signed acknowledgeme 2) Percent compliance we required restraint documentation. This reporting process will enof August 31, 2010.	mittee raint 010. I and cil raint 0. or raint 0. dit ss for N staff on d the ed by ent. ith	
	Patient #38's record	d contained a Progress Notes					

PRINTED: 06/29/2010 FORM APPROVED OMB_NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		130006	B, WI			1	C 0/2010
	PROVIDER OR SUPPLIER ES REGIONAL MEDIC	AL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 90 EAST BANNOCK STREET 30ISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ÔTD BE	(X5) COMPLETION DATE
	5/01/10 at 1:00 AM. the Restraints stated, FIV line again and wa and will "sedate/res "Demonstrates atte other life saving dev "Violent/self-destruct The Doctor's Order: was checked to Initiform was signed by 1:00 AM. At 1:05 A Versed (a medication and amnesia during hour as needed for Patient #38's MAR eversed on 5/01/10 at The medical record other less restrictive before the administrate record did not contained out, and the restrictive interventional must be a starting at 1:40 PM. #38's record. She sanot indicate why the stated the Versed would a other less restrictive medication was not 2. Patient #16 was a starting at 1:40 was a s	s. Restraint form dated The progress note side of little Clinical Justification for Patient #38 was pulling at her as expressing suicidal desire train PRN." The section of impts to remove airway or vices" and prive behavior were checked, as side of the Restraint form liate/Renew restraint use. This in the physician on 5/01/10 at M, the physician ordered on used to induce sleepiness a surgery) 4-6 mg IV every 1 excessive agitation. Indocumented she had received at 3:00 AM and at 6:28 AM. In did not indicate alternatives or a interventions attempted ration of the versed. The sin documentation that less ons had been considered and was interviewed on 6/09/10. She had reviewed Patient stated Patient #38's record did versed was given. She has ordered for anxiety and not document alternatives or interventions because the	Α.	186			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 43 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/29/2010 FORM APPROVED

	NO FUN MEDICARE	& MEDICAID SERVICES				OND NO.	0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		130006	B. WII	NG_	<u> </u>		C 0/2010
NAME OF F	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKI	ES REGIONAL MEDIC	AL CENTER		1	90 EAST BANNOCK STREET 30ISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
A 186	Continued From pa	ge 43	A	186			
	suicide watch and h record contained a 10:39 PM, that state belligerent and fight	rd documented she was on lad a 1:1 sitter. Patient #16's nursing note, dated 4/23/10 at led Patient #16 was, "very ing treatment and she was lints after which she became					
	that are designed to ankles, or chest of a from harming thems no documentation the offered or less restr	evices made of soft material safely fit around the wrists, a patient to prevent patients selves or others. There was nat alternative measures were acting Patient #16 in soft					
	10:10 PM, documer applied to both wrist #16. Patient #16 was on 4/23/10 at 10:47 documentation that offered or less restricted.	lowsheet dated 4/23/10 at atted soft restraints were as and the ankles of Patient as released from the restraints PM. There was no alternative measures were active interventions were acing Patient #16 in soft					
	Nursing Operations starting at 1:40 PM. record. She stated	tor of Accreditation and was interviewed on 6/09/10 She reviewed Patient #16's Patient #16's record dld not ictive measures were tried al restraints.					
		o ensure less restrictive ttempted prior to the use of TIENT RIGHTS:	A 1	87			

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 44 of 53

54/ 62

PRINTED: 06/29/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 130006 06/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 187 Continued From page 44 A 187 In response to A-187 RESTRAINT OR SECLUSION Action Plan Responsible Party: [there must be documentation in the patient's medical record of the following:] Bev Holland, MSN, RN, NE-BC. Administration St. Luke's The patient's condition or symptom(s) that Children's Hospital and Judy warranted the use of the restraint or seclusion. Jones, MSN, RN, NEA-BC, This STANDARD is not met as evidenced by: Administrator Women's Services Based on review of clinical records and interviews with staff, it was determined the hospital failed to Process Improvements: ensure that 1 of 1 patients, (#38), for whom ✓ Draft of revised restraint chemical restraints were used, had policy, order sets, checklist, documentation in the medical records of the conditions and/or symptoms that warranted the and audit process. Draft use of the restraints. The lack of documentation completed on June 29, 2010. prevented the hospital from ensuring patients Approval of revised Restraint were physically/chemically restrained only when policy and order sets. necessary to ensure their safety or that of others. The findings include: checklist and audit process. by August 31, 2010. Patient #38 was a 13-year-old female admitted ✓ The medical record for to the hospital on 4/30/10 after a self-reported patients on restraints will be polydrug ingestion. The ED History and Physical reviewed by the Nursing dictated by the physician on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a Administrative Supervisor or half bottle of Extra Strength Tylenoi, 2 full boxes Charge Nurse. Initiated by of caffeine pills, and 2 full boxes of Benadryl. The August 31, 2010. ED History and Physical stated that Patient #38 remained quite alert without obvious symptoms in Action Plan Implementation: the ED. The ED History and Physical stated that Patient #38's blood Tylenol levels were less than Management Council update 10. This was a normal result. The ED History regarding Restraint ordering and Physical stated the planned treatment was to and use. Held on June 17, repeat Patient #38's Tylenol levels, and 2010. "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations

FORM CMS-2567(02-99) Previous Versions Obsolete

or alterations in mental status as a result of her

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 45 of 53

;2083812861

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SU COMPLE	AVEY TED
•			A. BUI			(
,	,	130006	B. WIN	vG		06/10	0/2010
	ROVIDER OR SUPPLIER S REGIONAL MEDIC	AL CENTER		19	REET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET 101SE, 1D 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI GROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
A 187	Benadryl ingestion." Patient #38 was dis PM. The physician at 1:07 PM, stated I (increased heart rat pressure), change i Tylenol blood levels actually occurred." The hospital's restration if the hospital's restration if the Patient #38's record dated 5/01/10 at 12 #38 wanted her IV I saturation monitor of documented that Patient #38. The not physician came into Patient #38. The not Patient #38 that "sh treated" and told he need be. Patient #38's record and Doctor's Orders 5/01/10 at 1:00 AM. the Restraint form ti Restraints stated Patine again and was ewill "sedate/restrain "Demonstrates atter other life saving dev "Violent/self-destruct The Doctor's Orders Order	charged on 5/01/10 at 2:35 s progress note dated 5/01/10 Patient #38 had no tachycardia ie), hypertension (high blood in mental status, or increased if to suggest claimed ingestion aint log for the year of 2010 is as being restrained. If contained a nursing note, if AM, which stated Patient ine out and her oxygen off. The note further atient #38 stated, "It's my time it's my time. I had one thing to "The note explained that the other than the other and spoke with other stated the physician said to e had no choice but to get r that they would restrain her if I contained a Progress Notes is Restraint form, dated The progress note side of the Clinical Justification for atient #38 was pulling at her IV expressing suicidal desire and PRN." The section of impts to remove airway or	Α.	187	In response to A-187 conseducation regarding restruse. Held on June 22, 20 Nursing Practice Council Nursing Education Council Nursing Education Council Nursing Education regarding restruse. Held on July 6, 201 Administrative Supervise education regarding restruse. Held on July 7, 201 OAPI Integration: Implementation of an autool and reporting process the following metrics: 1) Percent of direct-care RN (excluding staff that are aleave) that have reviewed revised policy as indicated a signed acknowledgeme 2) Percent compliance we required restraint documentation. This reporting process will encof August 31, 2010.	mittee raint 010. I and cil raint 0. or raint 0. dit s for I staff on I the ed by ent. ith	
		the physician on 5/01/10 at					

;2083812861

56/ 62

PRINTED: 06/29/2010 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		130006	B. WIN		06/10)/2010
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		,
ST LUKE	S REGIONAL MEDIC	AL CENTER		00 EAST BANNOCK STREET OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS REFERENCED TO THE APPRICE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	1:00 AM. At 1:05 A Versed (a medicatic and amnesia during hour as needed for Patient #38's MAR Versed on 5/01/10's The medical record and/or symptoms th chemical restraint. statement, dated 6/ administered the Versed was because, Patient #3 during the night and medication." The hospital's Direct Nursing Operations starting at 1:40 PM. record. She stated include why the Ver- conditions and/or sy use of the chemical Versed was ordered staff did not docume symptoms that warr medication. The hospital failed to documented in Patie conditions and/or sy use of the restraints 482.13(e)(16)(v) PA OR SECLUSION	M, the physician ordered on used to induce sleepiness is surgery) 4-6 mg IV every 1 excessive agitation. documented she received at 3:00 AM and at 6:28 AM, did not indicate the conditions nat warranted the use of the However, in a written 11/10 by the nurse who exceed, the nurse documented is given to Patient #38 B woke up several times I requested "more of 'that' tor of Accreditation and was interviewed on 6/09/10 She reviewed Patient #38's Patient #38's record did not sed was given and the restraint. She stated the if or anxiety and so nursing ent the conditions and/or anted the use of the mptoms that warranted the restraint. She stated the if or anxiety and so nursing ent the conditions and/or anted the use of the mptoms that warranted the mptoms that wa	A 1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7EK211

Facility ID; 1D1LGZ

If continuation sheet Page 47 of 53

57/ 62

PRINTED: 06/29/2010 FORM APPROVED

06/10/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING

B. WING

A 188

NAME OF PROVIDER OR SUPPLIER

ST LUKES REGIONAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

A 188 Continued From page 47

The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

130006

This STANDARD is not met as evidenced by: Based on review of clinical records and interviews with staff, it was determined the hospital failed to ensure that 1 of 1 patient, (#38), for whom chemical restraints was used, had documentation in her medical record of the response to the intervention. The lack of documentation prevented hospital staff in assessing the effects of the interventions. The findings include:

 Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug Ingestion. The ED History and Physical dictated on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine pills, and 2 full boxes of benadryl. The ED History and Physical stated that Patient #38 remained quite alert without obvious symptoms in the ED. The ED History and Physical stated that Patient #38's blood Tylenol levels were less then 10. This was a normal result. The ED History and Physical documented the plan of treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations or alterations in mental status as a result of her Benadryl ingestion."

Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased

In response to A-188

Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services

Process Improvements:

- ✓ Draft of revised restraint policy, order sets, checklist. and audit process. Draft completed on June 29, 2010.
- ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010.
- ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010.

Action Plan Implementation:

Management Council update regarding Restraint ordering and use. Held on June 17. 2010.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 48 of 55

;2083812861

58/ 62

PHINTED: 06/29/2010 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 130006 06/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 188 Continued From page 48 A 188 Tylenol blood levels "to suggest claimed ingestion In response to A-188 cont... actually occurred." ✓ Medical Executive Committee The hospital's restraint log for the year of 2010 education regarding restraint identified Patient #38 as being restrained. use. Held on June 22, 2010. Patient #38's record contained a nursing note, Nursing Practice Council and dated 5/01/10 at 12:40 AM, that stated Patient Nursing Education Council #38 wanted her IV out and her saturation monitor education regarding restraint off. The note further documented that Patient use. Held on July 6, 2010. #38 stated, "It's my time to die, God told me it's my time. I had one thing to do, and I've done it." ✓ Administrative Supervisor The note explained that the physician had come education regarding restraint into the room and spoke with Patient #38. The use. Held on July 7, 2010. note stated the physician said to Patient #38 that "she had no choice but to get treated" and told OAPI Integration: her that they would restrain her if need be. Implementation of an audit Patient #38's record contained a Progress Notes tool and reporting process for and Doctor's Orders, Restraint form dated the following metric: 1) 5/01/10 at 1:00 AM. The progress note side of Percent of direct-care RN staff the Restraint formt title Clinical Justification for Restraints stated Patient #38 was pulling at her IV (excluding staff that are on again and was expressing suicidal desire and will leave) have reviewed the "sedate/restrain PRN." The section of revised policy as indicated by "Demonstrates attempts to remove airway or a signed acknowledgement. other life saving devices" and 2) Percent compliance with "Violent/self-destructive behavior" were checked. The Doctor's Orders side of the Restraint form required restraint was checked to Initiate/Renew restraint use. This documentation. This form was signed by the physician on 5/01/10 at reporting process will end as

FORM CMS-2567(02-99) Previous Versions Obsolete

1:00 AM. At 1:05 AM, the physician ordered

The 2010 Nursing Drug Handbook stated that Versed was a preoperative sedative and a medication for conscious sedation. The

Versed (A medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation.

Event ID:7EK211

Facility ID: ID1LGZ

of August 31, 2010.

If continuation sheet Page 49 of 53

:2083812861

59/ 62

FRINTED, UDIZBIZUTU FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 130006 06/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID COMPLETION DATE PREFIX PRÉFIX REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 188 Continued From page 49 A 188 medication was listed as to induce sleepiness and amnesia. Versed was listed as to be given before and/or during surgeries to induce general anesthesia. The listed dosing recommendations for children ages 12 to 16 was to initially give no more than 2.5 mg IV. The 2010 Nursing Drug Handbook stated that Versed dosing could be increased up to a total dose of up to 10 mg to reach the desired level of sedation. Patient #38's MAR documented she had received Versed on 5/01/10 at 3:00 AM and at 6:28 AM. However, a written statement, dated 6/11/10, by the nurse who administered the Versed, documented that the Versed was given to Patient #38 because, Patient #38 woke up several times during the night and requested "...more of 'that' medication," The medical record did not indicate the response to the intervention. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She reviewed Patient #38's record. She stated that all PRN medications should have documentation of effectiveness whether it was a chemical restraint or not. She did not find documentation of the effectiveness of the 5/01/10 at 3:00 AM and 6:28 AM Versed. The hospital failed to ensure staff documented in Patient #38's medical record her response to the chemicial restraint intervention. A 396 482.23(b)(4) NURSING CARE PLAN A 396 The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.

FORM CMS-2567(02-99) Previous Versions Obsoleto

This STANDARD is not met as evidenced by:

Event ID: 7EK211

Facility ID: ID1LGZ

If continuation sheet Page 50 of 53

07-13-10;03:02PM;ST LUKE'S BO! ADMIN DEPARTMENT OF HEALTH AND HUMAN SERVICES

;2083812861 # 60/ 62

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO.</u>	0938 <u>-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A, BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		130006	B. WI	NG		1	C 0/2010
	ROVIDER OR SUPPLIER	AL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉP TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETION DATE
	Based on staff inter records and hospital the hospital failed to were developed for whose medical records and plans. This renursing staff caring include: 1. Patient #2's med year old female who on 3/04/10 and was presented to the en 3/04/10 at 9:45 PM dictated at 12:43 AI #2 had fallen and storehead and lacerarequired suturing. Thought she had slip stated this was her emergency departm stated she had been infection and confus had returned later a related to dehydratisent home again be The report stated "I markedly depressed paranold and concern hospital." The report stated "I markedly depressed paranold and concern hospital." The report stated the rep	al policies, it was determined of ensure nursing plans of care of 2 patients (#2 and #14) ords were were reviewed for esulted in a lack of direction to for patients. The findings ical record documented an 81 or was admitted to the hospital of discharged on 3/05/10. She hergency department on A History and Physicial, M on 3/05/10, stated Patient utilities of her nose which the report stated Patient #2 oped and fallen. The report third admission to the nent in 2 days. The report in seen first for a urinary tract selon. The report stated she and been treated for confusion on. She was rehydrated and effore returning a third time. If yet the impression that she is do as well as somewhat with a somewhat with possibly some. The report stated her affect is oriented to person, place, it also stated Patient #2 did any distress but was tearful. It is plan was to admit Patient #2, possible consideration of a on and maybe transferred to [a hospital] for medication		396	In response to A-36 Action Plan Responsible Pacy Gearhard, MSN, RN, Administrator St. Luke's H Process Improvements: Focus on care plan documentation for paties placed on mental health restraints for violent beh suicide precautions, and behavioral health interventions by August 2010. Approval and implementations of care plan documentatis process by August 31, 20 Action Plan Implementations Implementation of the rescare plans will be facilitat through the Nursing Prace Council and Nursing Leadership Council. Implementation will be complete by August 31, 20	eart nts holds, avior, other 31, ation on 110. vised ted tice	
ハーバ しりつべりし	rievious versions	Obsolete Event ID: 7EK211		FRO	:IIIN ID: ID1LGZ If cootin	rustion sheat	Pero 51 of 5

;2083812861

61/ 62

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING

		130006	B. WIN	NG		06/10	0/2 <u>010</u>
	ROVIDER OR SUPPLIER S REGIONAL MEDIC	AL CENTER		18	EET ADDRESS, CITY, STATE, ZIP CODE 80 EAST BANNOCK STREET OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLQ BE	(XS) COMPLETION DATE
A 396	evaluation and adjust An Application of Codated 3/05/10 at 1:3 and filed with the cogravely disabled and involuntary hold. Patient #2's Interdis Plan, dated 3/04/10 plan related to her bissues. The plan state a high fall risk and in plan directing care fidocumented. Staff A, the nurse wild 3/05/10, was intervied She reviewed the mithe lack of a plan of A nursing plan of care Patient #2. 2. Patient #14's med year old male who wild 2/12/10 and was dis Diagnoses included delusion, and diabet documented on 2/15. An Application of Codated 2/15/10 at 5:3 and filed with the connected to be placed Nursing notes on 2/15 sexually inappropriated.	estment." commitment of the Mentally III, 11 PM, signed by the physician urt, stated Patient #2 was dineeded to be placed on an eciplinary Care Management and 3/05/10, did not contain a ehavior or psychological ated only that Patient #2 was eeded a bed alarm. No other or Patient #2 was eeded a bed alarm. No other or Patient #2 was edical record and confirmed care for Patient #2. The was not developed for the was not developed for the hospital on charged on 2/15/10. It dementia, homosexual es. An involuntary hold was 1/10. The mitment of the Mentally III, 1/10 PM, signed by the physician urt, stated Patient #14 on an involuntary hold. 1/10, stated Patient #14 was the with a male nurse and, on an intrusively wandered into	A	396	In response to A-369 con OAPI Integration: ✓ Implementation of an autool and reporting process the following metrics: 1) Percent compliance with complete and accurate placare for each inpatient. The reporting process will end of August 31, 2010.	dit es for a an of This	

FORM CMS-2567(02-99) Pravious Versions Obsolete

Event ID:7EK211

Facility ID: ID1LGZ

If continuation sheet Page 52 of 53

07-13-10;03:02PM; ST LUKE'S BOI ADMIN DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

;2083812861

62/ 62

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		130006		B. WING		C 06/10/2010			
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712				
(X4) ID PREFIX TAG	ERIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AT TAG CROSS-REFERENCED TO DEFICIE		OTION SHOULD BE OF THE APPROPRIATE			
A 396	Continued From page 52		A 396						
	Plan, dated 2/13/10 psychological status inappropriate behave patient was to have times a day and he with assistance. Of	disciplinary Care Management 1-2/15/10, did not mention his is or direction to staff regarding viors. The plan stated the his blood glucose checked 4 was allowed to be out of bed therwise, no nursing plan of							
	2/15/10, was intervi	igned to Patient #14 on ewed on 6/08/10 at 2:40 PM. nedical record and confirmed care for Patient #14.							
	A nursing plan of ca Patient #14.	are was not developed for							
	the hospital to ensu	66 as it relates to the failure of re the use of restraints were attents' plans of care.							
							,		
	17/02 đới Pavilous Vorilous				Manual CZ Manual CZ		Page Fa et Fa		

FORM CMS-2567(02-99) Provious Versions Obsolete

Facility ID; ID1LGZ

If continuation sheet Page 53 of 53

PRINTED: 06/16/2010 FORM APPROVED

Bureau of Facility Standards													
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATÉ SURVEY COMPLETED							
		130006		B. WING		06/1	0/2010						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
ST LUKES REGIONAL MEDICAL CENTER 190 EAST BANNOCK STREET BOISE, ID 83712													
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFÉRENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE							
BB115	BB115 16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND			BB115	In response to BB115 Action Plan Responsible Party: Joanne Clavelle, MS, RN, NE-								
	ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital.				FACHE A comprehensive plan of correction has been created	to	0. 0.10 a 2004 (0. -0.00 12 40 0.						
The state of the s	bylaws in accordant community respons	verning body shall ac ice with Idaho Code, sibility, and identify th	ę		address all findings relative A115. The plan of correction was reviewed and approved by	the	12.03B						
	least the following:	spital and which spec (10-14-88) Soverning Body, whic	·		St. Luke's Quality Commit of the Board of Directors of July 6, 2010 and the full Bo of Directors on July 13, 20	n oard	Constant and the second of the						
	i, Basis of selecting duties; and. (10-14				 The plan of correction was submitted to the Seattle CM Regional Office on July 9, 2010. 	is ""	Constitution and						
	il. Designation of of duties. (10-14-88)	ficers, terms of office	e, and		Process Improvements, Action Implementation, and OAPI	Plan							
	 b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) 				Integration: Process Improvements, Act	tion	300 3. 15010.						
					Plan Implementation, and QAPI integration for each finding cited under A115 is described in the Plan of		e engw						
	be maintained. (10-	•	gs shall		Correction submitted to the CMS Regional Office on Ju 9, 2010. A copy of this pla	ıly	10, 19 1 1, 1, 1, 1, 1						
	c. Committees, (12	-	17-4		has been enclosed.		A CONTRACTOR						
	committees as app	dy officers shall appo ropriate for the size a ospitals. (10-14-88)											
ABORATORY	MINECTOR'S OR PROVIDE	DER/SUPPLIER REPRESEN	TATIVE'S SIG	NATURE	TITLE CEO		(X8) DATE						
TATE FORM	n \			800	7EV211	If continu	ation sheet 1 of						

5/ 62

PRINTED: 06/16/2010 FORM APPROVED

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED ... AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/10/2010 130006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 111 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY **BB115** B8115 Continued From page 1 Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88)d. Medical Staff Appointments and Reappointments; (12-31-91) A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. 20.34 (10-14-88)iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtaliment of privileges, and delineation of privileges. (10-14-88)v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. Bureau of Facility Standards

STATE FORM

0529

7EK211

If continuation sheet 2 of 4

;2083812861

6/62

PRINTED: 06/16/2010 FORM APPROVED

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 130006 06/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) BB115 Continued From page 2 **BB115** (10-14-88)e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88)f. The bylaws shall specify an appropriate and regular means of communication with the medical staff, (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician.

Bureau of Facility Standards

STATE FORM

8009

7EK211

If continuation sheet 3 of 4

7/ 62 PRINTED: 06/16/2010 FORM APPROVED

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 130006 06/10/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 190 EAST BANNOCK STREET ST LUKES REGIONAL MEDICAL CENTER BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) BB115 BB115 Continued From page 3 In response to BB175 (10-14-88)Action Plan Responsible Party: Cy This Rule is not met as evidenced by: Gearhard, MSN, RN, Administrator Refer to A115 as it relates to the Governing St. Luke's Heart Body's fallure to provide sufficient oversight and Process Improvements: management necessary to ensure patients' rights Focus on care plan were protected. documentation for patients BB175 16.03.14.310.03 Patient Care Plans BB175 placed on mental health holds. restraints for violent behavior. 03. Patient Care Plans, Individual patient care suicide precautions, and other plans shall be developed, implemented and kept behavioral health interventions current for each inpatient. Each patient care plan by 8/31/10. shall include but is not limited to: (10-14-88) ✓ Approval and implementation a. Nursing care treatments required by the of care plan documentation patient; and (10-14-88) process by 8/31/10. Action Plan Implementation: b. Medical treatment ordered for the patient; and (10-14-88)Implementation of the revised care plans will be facilitated c. A plan devised to include both short-term and through the Nursing Practice long-term goals; and (10-14-88) Council and Nursing Leadership Council. d. Patient and family teaching plan both for Implementation will be hospital stay and discharge; and (10-14-88) complete by 8/31/10. e. A description of socio-psychological needs of **OAPI Integration:** the patient and a plan to meet those needs. Implementation of an audit tool (10-14-88)and reporting process for the following metrics: 1) Percent This Rule is not met as evidenced by: Refer to A166 as it relates to the hospital's failure compliance with a complete to incorporate restraint usage into patient care and accurate plan of care for plans. each inpatient. This reporting process will be completed as of Refer to A396 as it relates to the hospital's failure 8/31/10. to keep current a nursing plan of care.

Bureau of Facility Standards

STATE FORM

6866

7EK211

If continuation sheet 4 of 4



190 East Bannock Street Boiso, Idaho 83712

stlukesonline.org

Gary L. Flotcher, CEO

July 9, 2010

Sent via facsimile to (206) 615-2088

Steven Chickering Kate Mitchell CMS – Survey and Certification 2201 Sixth Avenue, RX-48 Seattle, WA 98121

Re: CMS Certification Number: 13-0006

Dear Mr. Chickering and Ms. Mitchell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated June 29, 2010, advising us of your determination that St. Luke's Regional Medical Center is not in substantial compliance with the Medicare hospital Condition of Participation – Patient Rights (42 Code of Federal Regulations (CFR) § 482.13) based on a complaint investigation authorized by the Centers for Medicare and Medicaid Services (CMS) and completed by the Idaho Bureau of Facility Standards on June 10, 2010.

Enclosed you will find our Plan of Correction, on Form CMS-2567, describing procedures we have implemented and/or begun to implement to improve the processes cited as deficiencies, as well as our plans for ongoing monitoring and tracking to ensure that the plan is effective and that the specific deficiencies remain corrected. The plan demonstrates how we are incorporating our actions into our quality assessment and performance improvement program to prevent the likelihood that any similar event(s) will recur. Mrs. Joanne Clavelle, Vice President for Patient Care Services and Chief Nursing Officer, will be responsible for implementing our Plan of Correction.

The deficiencies cited were of great concern to St. Luke's. Immediately following our exit conference with the surveyors from the Idaho Bureau of Facility Standards, we began to develop and implement the enclosed Plan of Correction. Ms. Mitchell, thank you for allowing us to discuss our case with you on July 2, 2010. We appreciated the opportunity to describe the materials that we had already submitted to the state agency as well as to your office, which included our immediate plan of correction ("Response to Preliminary Findings from the Bureau of Facility Standards Complaint Investigation, June 7-10, 2010"). As you will see on the enclosed Plan of Correction we are promptly and diligently addressing the cited deficiencies.



Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff

System General Counsel

General Counsel, Boise/Meridian

Enclosures

cc: Deb

Debby Ransom, Idaho Bureau of Facility Standards Gary Fletcher, CEO, St. Luke's Boise/Meridian Barton Hill, MD, VP Medical Affairs & CMO Pam Bernard, COO, St. Luke's Meridian

Chris Roth, COO, St. Luke's Boise

Joanne Clavelle, VP Patient Care Services & CNO, St. Luke's Boise/Meridian

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Eider Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 20, 2010

Gary Fletcher St Lukes Regional Medical Center 190 East Bannock Street Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **June 10, 2010**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004507

Allegation #1: Hospital physicians change medications without consulting the patient.

Findings #1: An unannounced visit was made to the hospital 6/07/10 through 6/10/10. During the complaint investigation, surveyors reviewed policies, interviewed staff and patients, and reviewed 39 medical records.

Review of 39 records, documented that physicians did consult and document coordination of medication management with patients and/or family members where it was determined appropriate. For example, in the record of one patient, who presented to the Emergency Department on January 7, 2010, physician's notes documented on multiple occasions that the physician met and talked to the patient about her medication concerns. The physician resumed all of the patient's home medications, but the hospital did provide some formulary substitutes. The notes documented the patients concerns and the resolution of the concerns. The complainant's physician was interviewed. She stated the patient was concerned with

Gary Fletcher July 20, 2010 Page 2 of 10

her medication management. The physician stated that she met with the patient on several occasions to discuss her concerns, as documented in her notes. The physician stated the patient was satisfied with the discussions.

Conclusion: Unsubstantiated: Lack of sufficient evidence

Allegation #2: Hospital physicians change patients medications without consulting the patients' primary physician.

Findings #2: The record of one patient, admitted to the hospital on January 7, 2010, showed the patient was admitted to the hospital only because a psychiatric bed was not available with in the community. The patient was placed on suicide watch and retained in the hospital until a bed became available at a psychiatric hospital. The physician who attended to the patient during her stay was interviewed. She stated the patient was medically stable, cognitive, and well versed in her medical conditions and medications. She stated that she reordered all of the patient's home medications with the exception of her long acting insulin. She stated because the patient was not eating at the time she felt it was not safe to reorder the long acting insulin until the patient was eating. At the point when the patient was eating her meals the long acting insulin was reordered. The record documented the patient's blood sugars were well controlled during her stay at the hospital. The physician stated she and the complainant reviewed, discussed, and made treatment decisions together. The physician stated the complainant was very involved and never requested her to consult another physician.

Additional patients' records reviewed, also showed appropriate coordination of patient care between physicians and patients.

Conclusion: Unsubstantiated: Lack of sufficient evidence

Allegation #3: Patients were being restrained without cause.

Findings #3: Medical records of 7 patients who were restrained in the year 2010 were reviewed.

One patient record reviewed documented that the patient had a history of seizures and, therefore, the physician wrote an order to have the patient placed on seizure precautions. Seizure precautions included placing the patient in a bed with all four side rails padded and in the upright position. There was no physician's order for restraints contained within the patient's medical record.

An interview was conducted with a hospitalist who took care of the patient. She

stated the patient was admitted for possible suicide attempt. She reported that the patient gave a medical history that included seizures. Due to the patient's medical history the patient was placed on seizure precautions. She said that seizure precautions meant close observation and all side rails padded to prevent injury and in the up position. She stated the patient was cognitive and her behavior was not violent or acting out and the patient did not have any physical deficits that would have prevented the patient from getting out of the bed. This was documented throughout the patient's medical record. The hospitalist confirmed that no orders were written for this patient to be restrained.

While the padded bed rails were used in an upright position, the patient had a staff member assigned to be with her at all time who could have put the rails down if requested to do so by the patient. This would allow the patient to get out of bed whenever she requested to do so. Therefore, in this situation, the bed rails were not considered a restraint.

However, the records of 2 of the 7 patients reviewed, showed physical and/or chemical restraints were used without evidence that less restrictive interventions had been considered and/or attempted prior to the use of the restraint. In addition, one patient's record did not include documentation of the patient's symptoms or behaviors that warranted the use of a chemical restraint. The record also showed the patient was given the medication used as the chemical restraint when the patient's documented behavior did not present a danger to the patient or others.

Therefore, based on information gathered related to the 2 patients noted above, the allegation is substantiated. Federal deficiencies were cited related to these findings.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #4: The hospital's housekeeping staff did not clean patients' rooms for up to 3 days, including urine of the floor.

Findings #4: One patient's complaint file contained an allegation that there was urine on the patient's floor and that housekeeping was not responsive in cleaning the patient's room in a timely manner.

Contained within the patient's complaint file was a hard copy of an email from the Clinical Supervisor of the Medical Floor to the Clinical Patient Relations Specialist. The email documented an investigation conducted by the Clinical Supervisor of the Medical Floor. The email documented that no one interviewed recalled urine on the

Gary Fletcher July 20, 2010 Page 4 of 10

patient's floor.

An interview with the Clinical Supervisor of the Medical Floor was completed. He confirmed that he interviewed at least 15 staff members and no one saw any urine on the floor in the patient's room or heard the patient complain of urine being on the patient's floor.

Five staff members who worked on the patient's floor were interviewed. All five staff members remembered the patient and all five denied seeing urine on the patient's floor. All five staff members believed that housekeeping was in the patient's room every day. During tours of the facility it was noted that the facility and patient rooms were clean.

No information was found to show that housekeeping did not clean patients' rooms, including floors.

Conclusion: Unsubstanciated lack of sufficient evidence

Allegation #5: Patients on a suicide watch were not provided privacy and items, such as soap, towels, shower curtain, and telephone were moved out of their rooms.

Findings #5: The hospital did remove items from the rooms of patients on suicide watch that could be used by patients to harm themselves. Patients on suicide watch were also provided 1 to 1 staff supervision. The hospital's policies supported these practices. During interviews, staff reported they would provide privacy to the best of their ability but were also responsible for ensuring patients did not harm themselves.

It was determined the hospital appropriately balanced patient privacy with the need to keep patients safe from harm.

Conclusion: Unsubstanciated lack of sufficient evidence

Allegation #6: Patients on suicide watch were not allowed to make phone calls.

Findings #6: The hospital's Care of Patients with Threatened or Actual Suicide Attempt policy stated, staff would remove any items from the room that could potentially be used for self-harm. The policy referred to the hospital's Safety Check List. The hospital's Safety Checklist instructed staff to remove telephone cords from the room and store them in a locked cupboard. Neither the policy, nor the checklist, provided direction to staff as to how to accommodate patient's telephone needs.

One patient's record reviewed documented that the patient was admitted to the hospital for a possible suicide attempt and was placed on suicide watch. A nursing shift note stated the patient was talking on the phone and then the phone was taken away.

Staff were interviewed. One staff member that worked with the patient stated the patient did have a cell phone during most of her hospital stay. He stated that this was an oversight and when it was identified the phone was removed. He stated that patients who were on suicide watch were not allowed a telephone.

The hospital's Social Service Supervisor was interviewed. He stated that patients on suicide watch did not have a telephone in their room. He was unsure as to how staff were to allow patients to use the phone.

An RN was interviewed. She stated that patients on suicide watch did not have a telephone in their room and were not allowed to use a telephone.

Another RN was interviewed. She stated that patients on suicide watch did not have a telephone in their room and she did not know how patients were to use the phone.

Two other staff interviewed stated it was up to the nurse as to whether patients on suicide watch could use a telephone.

The hospital was cited for a deficiency at 42 CFR 482.13(b) for a failure to promote patient rights by defining its policies and practices and allowing patients on suicide watch to use a telephone.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #7: The hospital did not honor a patient's advanced directives.

Findings #7: One patient record reviewed documented that the patient was admitted to the hospital for a possible suicide attempt. The patient's record contained advanced directives in the form of a physician orders for scope of treatment (POST) and a do not resuscitate (DNR) document. A POST is a standardized physician order that directs the patient's life-sustaining treatment if the patient lacks capacity to make decisions about their care. Effective July 1, 2007, the POST form replaces the former DNR in documenting and directing the patient's treatment wishes concerning life-sustaining treatment.

The patient's record contained a history and physical signed and dated. Within the document was a statement, in bold font stating, "The patient does have a POST on record and on file, however, given the patient's current suicide attempt and mental duress we will hold her POST at this time, with reevaluation as the patient's mental duress improves."

An interview was conducted on 6/08/10 beginning at 1:30 PM, with a hospitalist who took care of the patient. She stated the patient was admitted for possible suicide attempt. She noted that the patient had a POST and a DNR in the medical record. However, the hospitalist knew that the POST and DNR were invalid due to the attempted suicide. She said she told the patient that information. The patient was not happy but stated that she felt the patient understood the rationale.

Under Idaho Code, Title 39, Chapter 45, Section 39-4512C, it states that, "Health care providers shall make reasonable efforts to inquire...not caused by...with no indication of homicide or suicide."

The hospital did not honor the patient's advanced directives as they are directed not to do so by Idaho law.

Conclusion: Unsubstantiated; Lack of sufficient evidence

Allegation #8: The hospital did not meet patient's speciality diets to include a dietary consult.

Findings #8: An unannounced complaint survey was conducted on 6/7/10 to 6/10/10. A review of medical records and a staff interview was conducted.

One patient record reviewed documented that the patient had a medical history of diabetes mellitus type II. The patient's record also contained documentation of a physician's order, dated 1/07/10 at 3:45 PM, for an 1800 calorie American Diabetes Association (ADA) diet. The record also documented her known food allergies.

The record further documented the patient's blood glucose levels were well within normal limits during the patient's hospitalization.

An interview was conducted with the Supervisor of Room Service. He stated that when patients have special dietary needs the staff make every effort possible to accommodate all patients' requests. Patients can have snacks throughout the day and are provided 3 meals a day. He stated that if patients are not happy with the food they are provided they have many other options to choose from. He also stated that

dietary consults were made upon an order from the physician. He confirmed that there was no dietary consult ordered for this patient.

An interview was conducted with a hospitalist who took care of the patient. She stated the patient was very familiar with the disease processes, to include her dietary needs. She did not feel there was any reason for a dietary consult and the patient never requested a dietary consult. She stated that the patient consumed proper amounts of food and her blood sugars were well controlled. This was supported by documentation in the patient's record.

There is no evidence that the hospital failed to meet the patient's special dietary needs of the patient. Therefore the allegation was unsubstantiated.

Conclusion: Unsubstantiated; Lack of sufficient evidence

Allegation #9: A patient was manhandled by a hospital staff member, leaving finger prints on the patient's shoulder.

Findings #9: The hospital's complaint log was reviewed for the year 2010. There was one assault allegation reported to the hospital during 2010. The allegation was from the patient included in the complaint file was the patient was assaulted during the patient's hospitalization. The allegation was not received until sometime after the patient was discharged.

Contained within the patient's complaint file was a hard copy of an email from the Clinical Supervisor of the Medical Floor to the Clinical Patient Relations Specialist. The email documented an investigation was conducted by the Clinical Supervisor of the Medical Floor. The email documented that no one interviewed recalled the patient complaining about an assault.

An interview with the Clinical Supervisor of the Medical Floor confirmed that he interviewed at least 15 staff members and no one heard the patient complaining of an assault. He stated that the allegation was turned over to the local law enforcement agency, who conducted their own investigation and found the allegation to be unsubstantiated.

Five staff members who worked with the patient, were interviewed. All five staff members remembered the patient and all five denied hearing the patient complain of an assault.

Gary Fletcher July 20, 2010 Page 8 of 10

There is no evidence could be found that an assault took place.

Conclusion: Unsubstantiated; Lack of sufficient evidence

Allegation #10: The hospital did not provide a written response to patients' grievances.

Findings #10: A hospital policy, "Patient Concern, and Grievance Process," contained a section titled "Investigating and Responding." It stated an acknowledgement letter would be mailed to the patient/representative within 7 days of receipt of a formal complaint/grievance. The timeframe for review and investigation depended on the severity of the complaint/grievance. After the review was complete, the hospital would provide the patient with a written notice of its decision. Whenever possible, concerns and grievances would be resolved within 30 days of receipt. More complex grievances might require more than 30 days to reach resolution. The policy did not address the procedure to be taken if and when the hospital was not able to investigate or resolve the complaints within the time frames specified within the policy (whether they would contact the complainants to let them know of a delay).

A sample of ten grievances were reviewed. In four grievances, the hospital failed to respond to grievances consistent with hospital policies. There was a delay in sending acknowledgement letters to patients, investigating in a timely manner, and/or sending letters of resolution to patients or complainants. However, this was not true in the case of the patient identified in the complaint filed with the Bureau of Facility Standards.

During an interview with the Manager of Patient Relations stated it was their goal to resolve 90% of complaints and provide a written response within 30 days. In previous quarters they had met or exceeded this goal. She acknowledged that during the quarter beginning April 1, 2010, they had gotten behind, probably because they had been down one staff and another staff had been ill. She also stated it had been difficult at times to get responses from departments who were assigned to investigate complaints.

A hospital document written by the Manager of Patient Relations, titled Patient and Family Relations Quarterly Departmental Review 1st quarter and 2nd quarter FY 2010, dated 4/20/10, documented challenges facing the department. They included an increase in complaints, staff turnover of Patient & Family Relations staff, loss of one position, more complex complaints being receiving requiring more time, and the need for additional support (more Patient Relations Specialists, proactive program development, ongoing education throughout the organization).

Gary Fletcher July 20, 2010 Page 9 of 10

The hospital was cited at 42 CFR 482.13(a)(2)(iii) for failing to investigate, resolve, and respond to complainants in writing within a timeframe consistent with hospital policy.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #11: The hospital did not release medical record to patients and/or their families when requested.

Findings #11: Ten requests for release of medical records were reviewed. Eight out of the ten requests were responded to in an appropriate manner, including that of the patient identified in the complaint.

However, two record requests involving a parent of two adoptive children were not fulfilled. The hospital documented receiving medical record requests on 3/27/09 and 2/18/10 from an adoptive parent of two children. An interview was conducted with the Boise Health Information Management (HIM)Manager and the Director of Nursing Administration. The Boise HIM Manager acknowledged the two unfulfilled requests for medical records from an adoptive parent.

The hospital was cited at 42CFR 482.13(d)(2) for failure to protect and promote adoptive parents' rights to access medical information on their adoptive children.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Gary Fletcher July 20, 2010 Page 10 of 10

Sincerely,

PATRICK HENDRICKSON Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL Co-Supervisor Non-Long Term Care

PH/srp





C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, IO 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 19, 2010

Gary Fletcher St Lukes Regional Medical Center 190 East Bannock Street Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On June 10, 2010, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004526

Allegation #1: The hospital failed to release medical records to a legal guardian.

Findings #1: An unannounced visit was made to the hospital 6/07/10 through 6/10/10. During the complaint investigation, surveyors reviewed policies, interviewed staff and patients, and reviewed documentation related to requests for medical records involving 10 patients.

Review of hospital documentation indicated 8 out of 10 requests were released appropriately to patients or their legal guardians. However, the records related to 2 requests were inappropriately withheld. These requests involved a parent's request for release of medical records for two adopted daughters.

The hospital documented receiving medical record requests, on 3/27/09 and 2/18/10, from an adoptive parent. A computer-generated medical record form showed an "A" next to the patients' names, indicating the record request was still active or the request had not been finalized. A letter, dated 2/01/10, from a parent was attached to

one of the requests. In the letter, the parent stated she had made 5 prior requests for release of information in the previous 4 years, none of which had been fulfilled.

During an interview with the Boise Health Information Managment (HIM) Manager and the Director of Nursing Administration, record requests were discussed. The Boise HIM Manager acknowledged two unfulfilled requests (dated 3/27/09 and 2/18/10) for medical records from an adoptive parent for two daughters. She stated she realized in looking at the documentation that the hospital had not followed-up with the parent and should have done so and would do so. She also stated the first request had been shredded but should not have been shredded. Although the hospital would not have released the medical record information to the requestor based on the hospital's policy (referenced below), their department should have sent a response to the parent.

The hospital's policy, "Confidentiality and Security of Patient Information in HIM," stated that in order to protect all parties' identities, records on adopted infants would be released only by court order once the child had been discharged from the hospital and identifying information would be deleted unless the court specified otherwise.

The Boise HIM Manager was interviewed and her remarks were consistent with the above-referenced policy. She explained the hospital released information on adoptive children to the adoptive agency or an adoptive parent only by court order. When released, the information regarding the birth parents was "blacked out" to protect the privacy of the birth parents. When asked how the policy or practice was established, she explained it was based on information from the Idaho Hospital Association. Upon surveyor request, the Boise HIM Manager provided the reference from the Idaho Hospital Association.

The "Guidebook Issues in Health Care Management," published in 2008 by the Idaho Hospital Association had a section titled "Release of Information Regarding Adoptions." It recommended that each institution's policy stipulate that the adopting parents had the right to inspect the adoptee's medical records, consistent with state statues on minority. However, such inspection should not include the sealed birth certificate, nor identifying information on the child's birth parents. Thus, it was necessary for the institution to take measures to mask the identity of the birth parents.

During an interview surveyors asked the Boise HIM Manager how the hospital's policy to not release medical records to adoptive parents was derived from the reference provided (Guidebook Issues in Health Care Management). She stated she realized there was "a gap" and it would be necessary to revisit the policy and perhaps

Gary Fletcher July 19, 2010 Page 3 of 3

seek legal council on the appropriateness of withholding medical records from adoptive parents.

The hospital was cited for a deficiency at 42 CFR 482.13(d)(2) for a failure to protect and promote adoptive parents' rights to access medical information on their adoptive children

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON

Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

PH/srp



C. L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6826 FAX 208-364-1888

July 15, 2010

Gary Fletcher St Luke's Regional Medical Center 190 East Bannock Street Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On June 10, 2010, a complaint survey was conducted at St Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004633

Allegation: A patient's breast implant ruptured during a mammogram unit in 2007. Also, a breast sonogram report contained incorrect information.

Findings: An unannounced visit was made to the hospital on 6/07/10 to 6/10/10. Staff were interviewed. Ten medical records were reviewed of patients who had diagnostic breast procedures, including patients who had mammograms and/or sonograms.

Documentation for non-invasive outpatient procedures consisted only of radiology reports. Nurses and technicians did not document regarding the procedures or patients reaction to the procedures. This was consistent with community standards for Idaho. All patients had reports from a physician as to the findings of the tests.

One patient record documented a mammogram on 11/08/07. The radiology report, dated 11/08/07, stated the patient had a one centimeter hard mass in her right breast and had a right breast implant failure. This same patient had a sonogram of her left breast on 2/19/10. The radiology report stated the breast appeared intact and there were no suspicious lesions. A sonogram was not performed on the right breast. The report stated a bilateral diagnostic mammogram was recommended but the patient refused. There was no way to determine the accuracy of the reports.

The Manager of Breast Care Services was interviewed on 6/08/10 at 10:00 AM. She

stated the mobile mammography unit visited sites around the state. She stated staff at these site visits included a driver, a technician, and a nurse. She said there were no restrictions for mammograms for patients who had breast implants but they required eight radiologic views instead of four. She stated there had been no complications identified from mammograms in the past year. She also said the mammography and ultrasound departments participated in the hospital's quality improvement program.

No adverse reactions or complications were identified for patients who had diagnostic breast examinations. Reports appeared accurate.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES

Health Facility Surveyor

Non-Long Term Care

Aule & Sylvia Creswell
SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

GG/srp